

**THE INFLUENCE OF NURSING ORGANISATIONS ON THE DEVELOPMENT OF
THE NURSING PROFESSION IN SOUTH AFRICA: 1914-2014**

by

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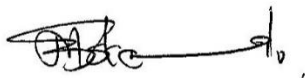
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I declare that **THE INFLUENCE OF NURSING ORGANISATIONS ON THE DEVELOPMENT OF THE NURSING PROFESSION IN SOUTH AFRICA: 1914-2014** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other education institution.



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ABSTRACT

The purpose of the study is to explore past and current professional nursing organisations by means of historical inquiry and to explain the factors that influenced the development of such organisations, as well as the contribution that these organisations made to the professional development of South African nursing in the period between 1914 and 2014. The researcher conducted a literature review and collected data from archival primary and secondary sources. *A priori* codes provided structure and historical context, yet allowed flexibility. Philosophically critical realism guided the research and enabled the researcher to explain and critique the social world in which South African nursing organisations historically functioned and exerted their professional influence. The findings revealed that in the past one hundred years political, economic and cultural factors present in the social world influenced the nature of South Africa's professional nursing organisations. Determined to create a female professional image, status and educational exclusivity, South African nursing leaders of the 20th century opted to establish the South African Trained Nurses' Association (SATNA), a professional nursing association. Influential associations such as SATNA and the South African Nursing Association (SANA) guided the profession to develop a nursing culture based on philosophical and ethical principles of practice. The result was a recognised, respected and trained nursing corps. Over time, however, a social class system, religion, political ideology and nurses' economic needs reshaped South Africa's nursing associations and consequently the profession. By the end of the 20th century, South African nursing leaders accepted that nurses needed their socio-economic welfare to be prioritised and therefore the Democratic Nursing Organisation of South Africa (DENOSA), a professional organisation with a trade unionist stance, was established. The result was a trained, politicised, fragmented nursing corps struggling to find its collective professional voice. The greatest

legacy bestowed on South African nursing by its first influential organisations is the professional associations evident today. Over time, the South African Nursing Association's discussion groups that had been established in the 1950s to discuss nursing-related topics evolved into the specialist groups and associations that were present in 2014.

Key terms

Associations; critical realism; historical inquiry; nursing; organisations; professional development; professional influence; professional nursing image; South Africa; trade unions.

DIE INVLOED VAN VERPLEEGKUNDIGE ORGANISASIES OP DIE ONTWIKKELING VAN DIE VERPLEEGKUNDIGE BEROEP IN SUID AFRIKA: 1914-2014

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OPSOMMING

Die doel van die studie is om die verlede en huidige professionele verpleegkundige organisasies deur middel van historiese navraag te verken en om die faktore te verduidelik wat die ontwikkeling van sulke organisasies beïnvloed het, sowel as die bydrae wat hierdie organisasies gemaak het tot die professionele ontwikkeling van Suid Afrika se verpleegkunde in die periode tussen 1914 en 2014. Die navorser het 'n literatuur oorsig gedoen en data versamel vanuit primêre argief bronne en sekondêre bronne. *A priori* kodes het struktuur en historiese konteks voorsien, maar het ook 'n mate van buigsaamheid toegelaat. Filosofies, het kritiese realisme die navorsing gelei en die navorser toegelaat om die sosiale wêreld waarin Suid Afrikaanse verpleegkundige organisasies histories gefunksioneer het en hulle professionele invloed beoefen het, te verduidelik. Die bevindings het onthul dat politiese, ekonomiese en kulturele faktore teenwoordig in die sosiale wereld, die aard van die Suid Afrikaanse professionele verpleegkundige organisasies beïnvloed het in die laaste een honderd jaar. Vasbeslote om 'n vroulike professionele status en onderwys eksklusiewe beeld te skep, het Suid Afrikaanse verpleegkundige leiers van die 20ste eeu gekies om die South African Trained Nurses' Association (SATNA) 'n professionele verpleegkundige assosiasie, te stig. Invloedryke assosiasies soos SATNA en die South African Nursing Association (SANA) het bygedra tot 'n verpleegkundige kultuur wat gebou was op filosofiese en etiese praktyk beginsels. Die resultaat was 'n erkende, gerespekteerde en opgeleide verpleegkundige korps. Oor die jare het 'n sosiale klasse sisteem, geloof, politieke ideologie en verpleegsters se ekonomiese behoeftes die Suid Afrikaanse verpleegkundige assosiasies en gevolglik die beroep hervorm. Teen die einde van die 20ste eeu, het Suid Afrikaanse verpleegkundige leiers aanvaar dat verpleegsters hulle sosio-ekonomiese

welsyn gepriotiseer wil hê, en daarom is die Democratic Nursing Organisation of South Africa (DENOSA), 'n professionele organisasie simpatiek tot vakbondwese gestig. Die gevolg was 'n opgeleide, verpolitiseerde, gefragmenteerde verpleegkundige korps wat sukkel om 'n kollektiewe professionele stem te vind. Die eerste invloedryke verpleegkundige organisasies se grootste nalatenskap aan Suid Afrikaanse verpleegkunde is die professionele organisasies wat vandag aktief is. Oor tyd het die South African Nursing Association gespreksgroepe wat in die 1950s gestig was om verpleegkundige onderwerpe te bespreek ontwikkel in die spesialis groepe en assosiasies wat nog in 2014 aktief was.

Sleutelwoorde

Assosiasies; kritiese realisme; historiese navraag; verpleegkunde; organisasies; professionele ontwikkeling; professionele invloed; professionele verpleegkundige beeld; Suid Afrika; vakbonde.

**UMTHELELA WEZINHLANGANO ZOBUNESI EKUTHUTHUKISENI UMKHAKHA
WOHLENGIKAZI ENINGIZIMU AFRIKA NGO: 1914 KUYA KU-2014**

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NGAMAFUPHI

Inhloso yalolucwaningo kwakungukuhlola izinhlangano zobuhlelengikazi ezikhona nezakudala ngomlando, ukuchaza izinto ezibenomthelela othize ekuthuthukisweni kwalezi zinhlangano nomnikelo lezi zinhlangano eziwufakile ngokungenamkhawulo ukuze kubenentuthuko esezingeni emkhakheni wobuhlelengikazi eNingizimu Afrika esikhatini esisuka ku-1914 kuya ku-2014. Umcwaningi wenze ukubuyekezwa kwezincwadi futhi waqoqa imininingwane evela emithonjeni eyinhloko neyokugcina. Amakhodi angaphambilini ahlinzeka ngesakhiwo nomlando oqoshiwe; kodwa futhi bavumela inkululeko. Ochwepheshe bezocwaningo bahola lolucwaningo bavumela umcwaningi achaze ngemibono yabantu, Inhlangano yezobuhlelengikazi eNingizimu Afrika isabenzise umlando ukuqhamuka nezinhlelo ezintsha okusebenza okusezingeni. Lokhu okutholakele kuveza ukuthi eminyakeni eyikhulu edlule yezombusazwe, ezomnotho nezamasiko ezikhona emhlabeni wezenhlalo zithonye isimo sezinhlangano ezihle zabahlengikazi zaseNingizimu Afrika. Ukuzimisela ukwakha isithombe sowesifazane sangasese, isimo nokuzibandakanya kwezemfundo, abaholi babahlengikazi baseNingizimu Afrika bekhulu lama-20 bakhetha ukusungula Inhlangano Yabahlengikazi BaseNingizimu Afrika (SATNA) inhlangano yabahlengikazi abaqeqeshiwe. Izinhlangano ezinamandla ezinjenge-SATNA kanye ne-South African Nursing Association (SANA) ziqondise lo msebenzi wokuthuthukisa isiko lobuhlelengikazi elisuselwa ezimisweni zefilosofi nezokuziphatha.

Imiphumela kwabayisidumbu somhlelengikazi ezaziwayo, ezihlonishwayo futhi eziqeqeshiwe Ngokuhamba kwesikhathi, kodwa-ke, uhlelo lwesigaba sezenhlalo, inkolo, imibono yezepolitiki kanye nezidingo zomnotho zabahlengikazi zakha kabusha izinhlangano zabahlengikazi zaseNingizimu Afrika futhi ngenxa yalokho umsebenzi.

Ekupheleni kwalelikhulu lama-20, abaholi babahlengikazi baseNingizimu Afrika bamukela ukuthi abahlengikazi badinga inhlala-kahle yezenhlalo nezomnotho yabo ukuze kubekwe eqhulwini ngakho-ke kwasungulwa iDemocratic Nursing Organisation of South Africa (DENOSA), inhlango yobungcweti enesimo sezinyunyana zabasebenzi. Imiphumela kwakuyisidumbu somhlengikazi, oqeqeshiwe, opolitikile, ongakwazanga ukubeka uvolwakhe. Mhlawumbe ke umlando omkhulu wezobuhlengikazi obekiwe namhlanje kulomkhakha wezobuhlengikazi ugqugqumezelwe ubufakazi obusezingeni bezinhlangano esezingeni enobufakaz Esikhathini esedlule ngo1950 izingxoxo zamaqembu ezathulwa e-SANA kudingidwa izihloko eziphathelele nezobuhlengikazi nokubandakanya amaqembu aphaathelene nokuthile aqondene nakho nobufakazi bamaqembu ngo2014.

Amagama asemqoka

Izinhlangano; ezibucayi; umlando ogciniweyo; ubuhlengikazi; izinhlangano; intuthuko esezingeni; umthelela osezingeni; Ningizimu Afrika; izinyunyane; Izinyunyana zabasebenzi.

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To the professional nurses of South Africa;
Learn from the past; work in the present;
Create the future.

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LIST OF ABBREVIATIONS

ANA	American Nurses' Association
ANC	African National Congress
ANCWL	African National Congress Women's League
BMA	British Medical Association
BNA	British Nurses' Association
BONA	Bophuthatswana Nursing Association
BTNA	Bantu Trained Nurses' Association
CINA	Ciskei Nursing Association
CNF	Commonwealth Nurses Federation
CNR	Council of National Nursing Associations Representatives
CNS	Colonial Nursing Service
CONSA	Concerned Nurses of South Africa
COSATU	Congress of South African Trade Unions
DASAN	Democratic Association of South African Nurses
DENOSA	Democratic Nursing Organisation of South Africa
ECSACON	East, Central and Southern African College of Nursing
FEDSAW	Federation of South African Women
FOSANAM	Federation of South African Nurses and Midwives
FPNL	Forum for Professional Nurse Leaders
HWSETA	Health and Welfare Sector Education and Training Authority
HOSPERSA	Health and Other Services Personnel Trade Union of South Africa
HRH	Her Royal Highness
ICN	International Council of Nurses
ILO	International Labour Organisation
INB	Interim National Board
KNO	KwaZulu Nursing Association
LONASA	League of Nursing Organisations of Southern Africa
NCW	National Council of Women
NEA	Nursing Education Association
NEDLAC	National Economic Development and Labour Council
NNA	Namibia Nursing Association
NNASA	Neonatal Nursing Association of South Africa
NPFF	Nurses Planning for the Future Forum
NSB	National Standards Body
NUM	National Union of Mineworkers
O.B.E.	Order of the British Empire
OBE	Outcomes Based Education
PSBC	Public Service Bargaining Council
RBNA	Royal British Nurses' Association
R.R.C.	Royal Red Cross
SACP	South African Communist Party
SACTU	South African Congress of Trade Unions
SADNU	South African Democratic Nurses' Union
SAIRR	South African Institute of Race Relations
SAMDC	South African Medical and Dental Council
SAMWU	South African Municipal Workers Union
SANA	South African Nursing Association

SANC	South African Nursing Council
SAQA	South African Qualifications Authority
SATNA	South African Trained Nurses' Association
SATS	South African Theatre Nurse Organisation
SAVF	Suid-Afrikaanse Vrouefederasie
SAVV	Suid-Afrikaanse Verpleegstersvereniging
SA War	South African War (previously 2 nd Anglo-Boer War 1899-1902)
S.C.M.	State Certified Midwife
S.R.N.	State Registered Nurse
TNC	Transitional Nursing Committee
TOP	Termination of Pregnancy
TRANA	Transkei Nursing Association
TRC	Truth and Reconciliation Commission
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UK	United Kingdom
USA	United States of America
VAD	Voluntary Aid Detachment Members
VENDA	Venda Nursing Association
WHO	World Health Organization
WWI	First World War (1914-1919)
WWII	Second World War (1939-1945)

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

Professional organisations aim to develop the identity of vocational groups, which in turn assist such groups to increase their value and status as workers (Geyer 2013:199). Organised groups of professionals can increase their authority and political influence, allowing such groups to achieve their stated objectives (Searle 1991:6). The first professional organisation, the British Medical Association (BMA), was established in 1832. The first female profession in the world to follow suit was the Royal British Nurses Association (RBNA) in 1887, under the leadership of Mrs. Ethel Gordon Bedford Fenwick (Marks 1994:15; Searle 1991:6, 15-16). A branch of the RBNA was established in Kimberley, South Africa, where Henrietta Stockdale worked as a district nurse and midwife from 1876.

By 1899, nursing's first international professional organisation, the International Council of Nurses (ICN), was established to create a collective voice that could advocate for nurses' rights as women and workers (Lynaugh & Brush 1999:4). In later years, professional organisations such as the Commonwealth Nurses' Federation, established in 1973, encouraged the development of professional nursing organisations in member states of the British Commonwealth. Subsequently, nursing organisations in the eastern, central and southern regions of Africa collaborated to promote the health of people in the region and to foster further cooperation amongst nurses of the region. With this goal in mind, the East, Central and Southern African College of Nursing (ECSACON) was established in 1988. The organisation functioned as a technical advisory group and had no physical office. Its fourteen member states included countries such as South Africa, Malawi, Zimbabwe, Mauritius and Botswana (Ndlovu, Phiri, Munjanja, Kibuka & Fitzpatrick 2003:223-224).

Against this historical background, South African nurses should recognise the important date of 1 October 1914. On that day, over 100 years ago, the first influential South African professional nurses' organisation was founded. The South African Trained Nurses'

Association (SATNA), “officially came into existence” on 1 October 1914 (Searle 1982a:17) and held its first meeting on 27 January 1915 in East London, Eastern Cape (Searle 1982a:19; Searle 1972:243). The ongoing involvement of South African nurses with professional organisations stems from this historical event. Arguably, professional organisations, themselves formed and influenced by dynamic forces active in society, have contributed to the development of the nursing profession over the past 100 years. South African nursing historians have not yet explored how these dynamic forces in society influenced their professional nursing organisations – and hence their profession.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

The research topic stems from recommendations for further historical research made in the researcher’s Master’s dissertation. The organisational transformation of the South African Nursing Association (SANA) into the Democratic Nursing Organisation of South Africa (DENOSA), and consequently its influence on the South African nursing profession, is yet to be explored (Esterhuizen 2012:152). The researcher’s keen interest in South African nursing history prompted her to explore the history and influence of nursing organisations such as SATNA, SANA and DENOSA. Professor Charlotte Searle’s memorial address to Dr John Tremble that honoured his contribution to the establishment of SATNA (Searle 1975:11-16) was a reminder that professional organisations can develop the nursing profession, providing it with moral guidance and a united voice.

1.2.1 Source of the problem

Throughout the history of South African nursing, there were discussions about the nature, purpose and types of professional organisation needed in nursing (Harrison 1982:4-6; Kunene, Nzimande & Ntuli 2001:35-41; Lubanga 2014; Marks 1994:125-132; Searle 1972:249-253; Van Huyssteen 1984:4-10). Similar discussions are evident in international nursing communities. Transformation in American nurses’ organisations was driven by factors such as changing legislation, social turmoil (such as war) and the development of specialised nursing skills for specialised hospitals (Matthews 2012).

Historically, South African nursing organisations also adapted and transformed. In 1914, the need for a professional nurses’ organisation led to the establishment of SATNA, a professional nursing association with voluntary membership (Harrison 1982:4-5; Searle

1982a:17-19; Searle 1972:242-243). With the promulgation of the first Nursing Act (45 of 1944), nurses favoured a compulsory professional association, namely SANA (Harrison 1982:5; Searle 1972:233-234; Searle & Pera 1993:82-85; Van Huyssteen 1984:4-10). In the 1990s DENOSA was established as a professional association with a trade union section (DENOSA [Sa]a:9; DENOSA 2014; Searle & Pera 1993:350). Today, nurses in South Africa not only have access to mainstream professional organisations such as DENOSA and the Health and Other Services Personnel Trade Union of South Africa (HOSPERSA), but also to specialist organisations such as the Forum for Professional Nurse Leaders (FPNL), the South African Theatre Nurse Organisation (SATS), the Neonatal Nursing Association of South Africa (NNASA) and the Nursing Education Association (NEA).

1.2.2 Background to the study

There is international (Matthews 2012) and local evidence that nursing organisations re-evaluate their role and purpose when circumstances in society change, and consequently undertake organisational transformation (note sub-section 1.2.1). This thesis explores South African nursing organisations' transformational changes, identifies the historical factors which necessitated such changes and reflects on how they influenced the profession.

1.2.2.1 The role and value of professional organisations

Any vocation/occupation (such as nursing) which strives to be recognised as a profession must have certain characteristics. These characteristics include a specialised set of skills based on a unique body of scientific knowledge, which is continuously updated and used to raise the standards of practice. Members use their skills and knowledge for the benefit of society and therefore a social contract exists between society and that group. Their specialised knowledge and skills allow vocational members to enjoy a right to autonomy in practice – which in turn implies accountability for actions. The vocational group therefore adheres to a strict ethical code and uses a system of self-regulation to ensure that members adhere to this ethical code (Cruess, Johnston & Cruess 2004:74; Matthews 2012; Searle & Pera 1993:83).

To maintain a professional culture, active participation in a professional organisation is required (De Swardt 2012:217, 221-222). The role of the professional nursing organisation is therefore to “articulate nursing values, integrity, practice and social policy, [and] demonstrate advocacy and self regulation” (Matthews 2012). In this way, professional organisations have a positive influence on the welfare of society. Ultimately members of society benefit from the work done by strong professional organisations (National Business Education Association 2010).

Professional organisations also add value by providing their members with a means of professional development. Members have access to scientific publications and research conferences, which ensure that they are informed of changes in practice and have network opportunities. By encouraging professional activities, organisations contribute to creating a pool of suitably qualified, knowledgeable professionals who can safely be employed (McQuide, Millonzi & Farrel 2007; National Business Education Association 2010).

An organised body of professionals provides their profession with a collective voice (Fisher 1997:329). It serves as a forum where issues, such as ethics and the type of professional organisation required, can be debated. This collective professional voice can represent its members in negotiations with governments and employers and, most importantly, advocate for the needs of its clients (McQuide et al 2007). Professional organisations have the important task of informing society and policy makers on issues specifically related to their speciality (Matthews 2012; National Business Education Association 2010; Raines [Sa]).

1.2.2.2 Types of professional organisations

Predominantly, two types of organisation are evident in the literature: trade unions and professional associations. A third option is the concept referred to as professional collectivism, which is an organisation that has both trade union and professional association characteristics. Trade unions and professional associations are often viewed as opposing entities because they differ in the culture they create, the values they support and the reasons for the actions that they take (Hovekamp 1997:232-244; Lubanga 2014; Marks 1994:125-132; Searle & Pera 1993:82-85, 341; Van Huyssteen 1984:5-10).

1.2.2.2.1 Professional associations

Although a professional association can involve itself in the socio-economic welfare of its members, this is not its primary focus; rather, the development of the profession is its central concern. A professional association busies itself with matters pertaining to professional knowledge, and, in the case of nursing, the greater good of public health (Fisher 1997:321; McQuide et al 2007). Using a timeline, Matthews (2012) illustrates how the nursing profession in America has contributed to the standards and ethics of nursing practice since the establishment of professional nursing associations in 1873. South African authors Kunene et al (2001:35) state that nurses “enter into an unwritten contract with society”. Society values nurses’ commitment to providing high-quality care and it trusts that nurses will do no harm. Any unprofessional behaviour by nurses will break this trust and harm the professional image of nursing. The existence of this close bond between nursing and society is also emphasised by Kotzé (2013:62) and Matthews (2012).

In the 1980s and the 1990s, the World Health Organization (WHO) supported the establishment of professional nurses’ organisations because nursing associations played a vital role in promoting and developing the nursing profession. Nursing associations contributed by determining and interpreting the role of nurses within the health-care delivery system (Searle & Pera 1993:341). The value of a professional association is that it speaks on behalf of the profession (Fisher 1997:329; Matthews 2012). The Dynamic Consumer-Content Model (Bergman 1983:18-24; Van Huyssteen 1984:5-10) explains the six key characteristics of a professional association, namely:

- A core area that supports professional socialisation and ethical behaviour
- Support and planning of professional education
- Matters pertaining to services and practice
- The socio-economic welfare of members
- A focus on research
- Involvement in policy development

Professional collectivism allows for a professional association to have a trade union branch with nurses to represent the specialised needs of nurses (Marks 1994:206;

Matthews 2012; Searle & Pera 1993:353-354). South African authors Searle and Pera (1993:353-354) caution that this version of trade unionism must be managed by a strict ethical code which considers the needs of the patient as well as those of the nurse. Collective activism must be guided by nurse leaders' knowledge of history. It provides the profession with a clear understanding of any situation and in this way influences decisions made by the profession (Holme 2015:2).

1.2.2.2.2 Trade unions

The primary focus of trade unions is the socio-economic welfare of its members. Searle and Pera (1993:942) define a trade union as a group of persons belonging to a specific occupation who unite to protect and promote their interests by means of collective bargaining. This approach assists employees in solving conflicts of interest that may arise between themselves and the employer. Trade unions busy themselves with matters such as closed-shop agreements, collective bargaining on behalf of the workers, unfair labour practice issues and, as a final resort, strikes (Searle & Pera 1993:343-347, 351).

Internationally, by the 1990s, trade unions for nurses existed in countries such as Australia, New Zealand, Britain and the United States of America (USA). In Britain, the *Royal College of Nursing* was a combination of professional organisation and trade union, but members did not have the right to strike. Clark and Clark (2006:6-7) state that although trade unions have increased their efforts to unionise American nurses since the 1990s, nurses were slow to join unions, as they believed that membership of a union was inappropriate and unprofessional. Unions were believed to concentrate on salaries and workplace benefits without considering the needs of the patient, a situation that most nurses find unacceptable (Clark & Clark 2006:7-8).

The perception that unionised nurses might disregard the health needs of patients was confirmed by research done in the 1990s in South Africa. Kunene et al (2001:36-39) state that although KwaZulu-Natal community members viewed the nursing profession positively, 84% of respondents felt unsafe with nurses belonging to non-nursing, politically affiliated unions. Community members feared that the ability of nurses to provide nursing care despite differences in political affiliation might be compromised.

1.3 RESEARCH PROBLEM AND STATEMENT

Professional organisations are tasked with the responsibility of protecting society by encouraging professional development and socialisation. Such activities confirm the professional status of a vocational group (such as nursing) and explain that group's unique bond with, and responsibility for, society. For this reason, it is also important that members of the professional group actively participate in reputable professional organisations. In turn, professional organisations periodically evaluate (and adapt) their role and purpose to ensure that they remain aligned with the needs of the profession and the society they serve (De Swardt 2012:217, 221-222; Kunene et al 2001:35; Matthews 2012).

Evidence of South African professional nursing organisations re-aligning themselves with the needs of their members and wider society is evident throughout their 100-year (1914 to 2014) existence. DENOSA (formerly SANA), the oldest and currently the largest (74 883 members in 2012) professional nursing organisation in the country, transformed from its 1944 status as an independent, professional nurses-only association to being one of the smaller affiliates of COSATU. In this large general workers' trade union federation, DENOSA's contribution to membership in 2012 was 3.42% (COSATU 2011:202; COSATU 2012:6; Esterhuizen 2012:101).

The history of the development of South African nursing organisations from 1914 to 2014 has not yet been recorded nor analysed. In the light of the significant changes that have occurred in the largest South African professional nursing organisation, there is a surely a need to analyse the history of all South African professional nursing organisations, to identify changes that have occurred and to explain the intended purpose and significance of these changes. What factors influenced the development of these organisations and consequently the nursing profession and wider society?

1.4 AIM OF THE STUDY

By means of historical inquiry, the study aims to contribute to the recorded history of South African professional nursing organisations.

1.4.1 Research purpose

The purpose of the study is to explore past and current professional nursing organisations by means of historical inquiry to explain the factors that influenced the development and nature of these organisations, as well as to understand the contribution that these organisations have made to the professional development of South African nursing in the period between 1914 and 2014.

1.4.2 Research objectives

The research objectives of the study are to:

- Explain the factors that influenced the development of South African nursing organisations from 1914 to 2014.
- Explain how changes in nursing organisations over time influenced the professional development of South African nursing.
- Describe the professional, social, political and educational functions of South African nursing organisations and the factors which led to their professional growth and/or demise.
- Illustrate the unique histories of South African nursing organisations which created an independent, recognisable professional presence in South African society and assisted in the professional socialisation of nurses in South Africa.

1.5 SIGNIFICANCE OF THE STUDY

The study aims to contribute to the science of nursing by explaining the historical significance of South African nursing's professional organisations. The study uses critical realism to provide philosophical guidance in identifying those causative forces which influenced the development and nature of professional nursing organisations and hence the development of the profession itself. The study explains how the choice of organisation (trade union or professional association) influenced the professional status of nurses in South Africa. The study also contributes to the professional socialisation of nurses by providing them with a philosophical foundation from which they can reflect and debate matters influencing their chosen profession.

The study is also significant because it illustrates and explains a part of South African nursing history that has not yet been analysed by means of historical inquiry. The standard South African nursing history sources were written in 1965 (Searle), 1990 (Mellish) and 1995 (Mashaba). None of these sources contains a comprehensive analysis of the factors that influenced the nature of South African nursing's professional organisations, and their consequent influence on the nursing profession. Further, these classic sources do not explain the period of organisational transformation that occurred after 1994, when South African nurses chose to merge several existing professional associations (the largest being SANA) into one professional organisation with a trade union section (DENOSA). In this, the study is unique and significantly contributes to knowledge of the professional history of South African nurses in the last 100 years.

1.6 DEFINITION OF CONCEPTS

In the thesis, the concepts listed below are defined as follows:

1.6.1 Historical documents

Historical documents are evidence of past events stored in libraries, archives, museums and private collections. They may include any medium, such as written records, photographs, and literature or art forms (Nieuwenhuis 2010b:73). In this study, *historical documents* are viewed as any historical evidence related to professional nursing organisations.

1.6.2 Primary sources

Primary sources are original historical documents, also referred to as archival data (Nieuwenhuis 2010b:73). Primary sources are eye-witness descriptions of historical events (Francis 2013:58; Kruman 1985:113; Lewenson 2008:34; Sweeney 2005:70). In this study, they include minutes of meetings, newspaper clippings, newsletters, conference and event programmes found in archives and private collections, as well as photographs taken by the researcher.

1.6.3 Secondary sources

Secondary sources are the works of authors who have written indirectly about the historical period covered in this study (Nieuwenhuis 2010b:73; Sweeney 2005:70). In this specific context, they are books about the history of nursing organisations written by authors who were not present during the historical events they discuss.

1.6.4 Nurse

The term refers to an individual who is trained in the professional art of promoting and maintaining the health of societies, communities, families and individuals (*Medway's Pocket English Dictionary* 2003:361; Searle & Pera 1993:171) and who is registered to practise (South Africa 2006:6).

1.6.5 Nursing

The term refers to the act of promoting and maintaining the health of societies, communities, families and individuals by a nurse who provides care and treatment for health-care users (South Africa 2006:6).

1.6.6 Professional associations

A professional association is “a group of people organized for a joint purpose” (*Concise Oxford Dictionary* 2004). In this study, the focus is on groups of professionals who, as a collective, set standards of practice and ethics for their chosen profession – thus creating a unified professional culture (Hovekamp 1997:234, 236).

1.6.7 Trade unions

A trade union means the formation of professional and/or non-professional groups with the primary purpose of collectively bargaining with employers on behalf of the groups, with a particular focus on worker rights and privileges (*Concise Oxford Dictionary* 2004; Hovekamp 1997:234, 236-237; Searle & Pera 1993:351). In this study, the focus is on trade unions that have historically influenced the South African nursing profession.

1.6.8 Professional organisations

The term refers to people organising themselves into groups with a specific purpose in mind (*Concise Oxford Dictionary* 2004; *Medway's Pocket English Dictionary* 2003:370). For this study, the term will be used to refer collectively to professional associations and trade unions.

Except for direct quotes from primary sources, references to persons' racial origins are made by using the words Black people, White people, Coloured people and Indian people.

1.7 FOUNDATIONS OF THE STUDY

Tholfsen, in Streubert and Rinaldi Carpenter (1995:197-198), states that "history lacks a coherent theoretical and conceptual structure" and explains that "[N]o one theoretical framework exists for which to study history." This implies that the historian may use different theoretical structures to organise data. In this study, the researcher used critical realism to provide the philosophical underpinnings for the historical inquiry. Detailed discussions of the research philosophy and methodology are presented in Chapters 2 and 3.

1.8 RESEARCH DESIGN

By means of historical inquiry, this qualitative study explores the historical significance and influence of professional nursing organisations on South African nursing. Sweeney (2005:62) confirms that historical inquiry is valuable if nurses wish to investigate the social, political, economic and historical context of decisions made and that affected the practice of nursing in a particular period.

Historical inquiry requires a vigorous, inquisitive search for historical truth (Francis 2013:57-58; Galgano, Arndt & Hyser 2008:1, 3). The search for historical truth requires a disciplined and meaningful representation of the data recorded in a narrative form (Lewenson & Hermann 2008:13, 18). The trustworthiness of these research findings is enhanced (Nieuwenhuis 2010b:74) because of the use of mostly primary sources.

1.9 RESEARCH METHODS

In this section, the research methodology is summarised in table format with reference to the data sources, data collection and data interpretation. A detailed discussion is found in Chapter 3.

Table 1.1 Summary of research methodology

Data sources	Literature about professional nursing organisations Primary sources in South African archives and private collections Secondary sources in libraries and online data bases
Data collection	Purposive search of archives, private collections, libraries and online data bases
Data analysis	Repeated cycles of data collection and reflection enabled the recording of rich, thick descriptions <i>A priori</i> codes provided structure and historical context, yet allowed flexibility

1.10 TRUSTWORTHINESS

Historical inquiry is a qualitative research design (Nieuwenhuis 2010b:70). Qualitative researchers, especially those supporting a critical realism philosophy, accept the existence of multiple realities. To ensure that the interpretation of a historical event is credible, the qualitative researcher becomes immersed in the research data. Thus, data analysis is subjective and influenced by the researcher's personal history (Graneheim & Lundman 2004:106, 111; Hallet 2008:155). The researcher adhered to the principles of trustworthiness: namely credibility, dependability, conformability, transferability and authenticity. Chapter 3 contains a detailed discussion about issues of trustworthiness and how it was applied in the study.

1.11 ETHICAL CONSIDERATIONS

Ethical clearance for the research was obtained from the University of South Africa's Department of Health Studies (note Annexure A). Although researcher subjectivity is supported by critical realism's philosophical stance (Benton 2011:2-3) and acceptable

within the qualitative, historical inquiry methodology, it creates the risk that the researcher's biases might unduly influence the data analysis (Lewenson & Hermann 2008:38). The researcher therefore used bracketing and reflection, as suggested by Lewenson and Hermann (2008:38) and Rolfe (2006:307), to recognise and uncover any preconceived ideas and to ensure that the research findings are comprehensively presented within an acceptable historical context. Chapter 3 contains a detailed discussion about the ethical principles applied in the thesis.

1.12 SCOPE AND LIMITATIONS OF THE STUDY

The researcher studied the development of nursing organisations and their influence on South African nursing during the first one hundred years of their professional existence. To provide historical context and to identify factors that had a direct influence on the development of professional nursing organisations, some historical events that occurred before 1914 were included.

This research was limited to the study of South African nursing organisations from 1914 to 2014. Although reference has been made to the South African Nursing Council (SANC), a detailed history of nursing's governing body was not the focus of the thesis. Similarly, the study refers to international nursing organisations with links to South African nursing organisations, but an in-depth discussion of the former was not within the scope of the thesis.

The limitations of the study relate to access to archives and archival material. Although the researcher was able to access South African archival materials that were created before 1998, documents created after that date have not yet been classified as archival material. The researcher's access to primary sources for the period 1998-2014 was therefore limited. Due to time constraints and travel costs, the researcher also did not visit any international archives.

1.13 STUDY OUTLINE

The thesis commenced with a summary of the research problem, research objectives and research methodology in Chapter 1. Chapter 2 discusses the philosophical framework that guided the research, and is followed by an explanation of the research methodology

in Chapter 3. Both Chapters 2 and 3 contain explanations of how the philosophical framework informed the historical inquiry.

The written narrative in Chapters 4 to 8 focuses on significant historical events (an issue-based narrative) instead of a strict chronological order. There are instances where more than one chapter contains reference to the same *a priori* period (note Table 1.2). These repeated references are important because they confirm the interconnected (linked) nature of history. One historical event follows an earlier historical event; but that one event also has the potential to create the circumstances in which future events occur. At the end of each chapter, the researcher used the critical realism framework to identify the causative events and agents that were identified in that *a priori* period. This represents the vulnerable insights (preliminary conclusions that might still change as the inquiry continues) derived from the narrative.

The narrative represents the data collection and analysis phases of the historical inquiry. Thick descriptions create a continuous narrative that conveys historical context and creates pattern and meaning (Barroso 2010:115; Brundage 2013:10, 17). In the thesis, thick descriptions of the historical events and factors that influenced the development of professional organisations in South Africa contribute to the credibility and dependability of the research conclusions.

In Chapter 9, conclusions (the invulnerable insights) are drawn about the factors that historically influenced South African nursing organisations and the subsequent influence of these organisations on the development of the nursing profession. The limitations of the study are stated, and recommendations for further research are made. The researcher also states the contributions that the study makes to the scientific body of knowledge.

Table 1.2 Chapter topics and chronology evident in the narrative

Chapter 1	Introduction to the research problem, objectives and methodology
Chapter 2	Philosophical framework: critical realism
Chapter 3	Research methodology: historical inquiry
Chapter 4	The first professional nursing organisations (1830s-1919)
Chapter 5	The first South African nursing organisations (1914-1944)
Chapter 6	The trade union crisis and South African nursing (1942-1944)
Chapter 7	The influence of socio-political events on South African nursing (1940s-1970s)
Chapter 8	Transformation in South African nursing (1970s-2014)
Chapter 9	Conclusions, limitations, recommendations and contributions

1.14 SUMMARY

This chapter provides a brief outline of the historical research that was conducted. Critical realism informed the research methodology. The research problem is that South African nursing historians have not yet explored the social forces that influenced their professional nursing organisations and the nursing profession. The researcher's purpose is therefore to explore the history of these nursing organisations and to explain the factors that influenced their development and nature, as well as the contribution they consequently made to the professional development of South African nursing. The research focus was South African nursing organisations that existed (or still exist) in the past 100 years (1914-2014). The limitations of the study were that the researcher did not visit international archives. Access to primary sources written after 1998 was also limited. During the research process, the researcher used bracketing and reflection to recognise and limited research bias.

In the next chapter the researcher discusses the philosophical framework that guided the research process.

CHAPTER 2

PHILOSOPHICAL FRAMEWORK: CRITICAL REALISM

2.1 INTRODUCTION

Historians accept that multiple realities exist (Francis 2013:57) and they conduct historical inquiry with the purpose of recording historical truth. To obtain such historical truth, the researcher contemplated past events through a philosophical lens that enabled a new social perspective to emerge from the historical data. The researcher used critical realism in the study, because it is a philosophical stance that encourages one to ask fresh/different questions about the phenomena of interest.

This chapter explains critical realism and illustrates how its philosophical underpinnings inform historical inquiry.

2.2 CRITICAL REALISM: ONTOLOGY AND EPISTEMOLOGY

Herring and Stokes (2011:5) explain that “critical realism relates epistemological relativism ... to ontological realism ... through judgmental rationalism”. They explain that there is an influential social reality about which we know a little, but not everything. Knowledge about it is obtained indirectly or by interpretation. Testing this knowledge against social reality can only be done by indirect interpretation, knowing that such testing is fallible.

2.2.1 Epistemology

As a philosophy, critical realism is positioned on the epistemological continuum, somewhere between positivism (the world is a closed system with constant properties) and constructivism (the world derives its meaning from human interpretation) (Burgoyne 2011:2; Clark 2012:2-3; Fletcher 2017:181-182). This positioning allows critical realism to support many research methodologies (Schiller 2016:93).

Critical realists maintain that the researcher should not declare an epistemological position at the beginning of a study. Although some events are often present in the world, the regularity at which an event occurs (the event regularity) is not always predictable. The possibility that the event might not regularly occur implies that there are some unnoticed reasons that cause such event irregularity. Even the unnoticed reasons themselves are not predictable; depending on the situation and context they will exert an effect – or not (Burgoyne 2011:2-3). Critical realists therefore challenge the two absolute but opposing assertions that knowledge is independent of humans (objectivism/positivism) or that scientific inquiry is socially embedded and therefore fallible in nature (relativism/constructivism). Critical realism's position in the middle of the epistemological continuum allows the researcher not only to describe events, but also to identify unnoticed reasons (causes) that have the potential to initiate social change (Clark 2012:2; Fletcher 2017:181-2). It also encourages the historical researcher to find new reasons why events occurred in the first place. In this way, critical realism guides the researcher to ask new questions about historical events of interest.

2.2.2 Ontology

Critical realists assert that reality is an open, dynamic system with emergent properties (Burgoyne 2011:3). By considering reality as a complex, multi-layered open system influenced by agents and structures, a fresh ontological stance becomes possible.

There is more to know about social reality than what we know. Human understanding of social reality is incomplete, because there are numerous causal mechanisms that interact simultaneously (now and in the past) to create the social world (Archer 2010:200; Herring & Stokes 2011:10-11; Walker 2017:116). It may be surmised that there are numerous emergent properties and powers that, depending on specific circumstances, simultaneously interacted in diverse ways to cause a variety of effects (Archer, Sharp, Stones & Woodiwiss 1999:12; Lonergan 1970:211). Based on this interpretation of social reality, any inquiry into the historical influence of nursing organisations on the professional development of South African nursing would become a complex study. Critical realism's philosophical stance assisted the researcher to identify those interacting, influencing and even conflicting mechanisms (e.g. the changing role of women in 20th-century society) that were present within South African nursing structures specifically, and society in

general. It was those causal mechanisms which contributed to changes in the professional nursing structures and consequently the profession itself.

Critical realists accept that there are three reality domains: the *actual*, the *real* and the *empirical*. The actual domain represents world events that occurred (whether observed or not), while the real domain refers to the veiled, often unobserved structures and relationships that influence the actual domain. Depending on the circumstances, these hidden structures and relationships (causal mechanisms), when activated, create unique effects (events) (Benton 2011:3; Fletcher 2017:183). Critical realism's actual domain is evidence of hidden powers interacting within a specific context in the real domain (Lonergan 1973:38; Schiller 2016:89). Lastly, the empirical domain represents a person's imperfect account of what he or she observed of the social world. Critical realism expresses willingness to consider the actual and the real domains from this imperfect perspective. However, precisely due to an individual's imperfect perspective, the actual and the real domains are not known with cast-iron certainty. Therefore, events and all their underlying causes should be considered (Burgoyne 2011:3-4; Clark 2012:2-3; Elger 2012:3). This philosophical stance allowed the researcher to identify the very basic realities of historical events.

In this thesis, the actual is represented by the 100-year history of South African nursing organisations. The empirical represents the current interpretation of that history. A focus on the real domain of critical realism allows the researcher to shed new light on the history of the country's nursing organisations. The focus moves away from what is known and accepted as historically factual. Rather, the researcher seeks to identify the causal mechanisms which were historically present and that exerted influence on South African nursing organisations and consequently the nursing profession. A new ontology related to the history of South African nursing organisations becomes possible, as the focus moves away from what events occurred to what caused those events to occur.

An analysis of articles (Clark 2012:2-3; Elder-Vass 2015:82; Fletcher 2017:183; Schiller 2016:89-90) that explain critical realism concepts led the researcher to reflect on the philosophy's applicability to the research methodology used in this thesis, namely historical inquiry. The researcher drew inspiration from Schiller's (2016:90) circular representation of critical realism's three domains to illustrate how historical inquiry is positioned within critical realism's real domain. Figure 2.1 represents the researcher's

understanding of critical realism and its connection to historical inquiry as a methodology. Of note is that the researcher presents the diagram's outer line (representing the real domain) as a broken line to illustrate the openness of the social system and to suggest that there is knowledge yet unknown.

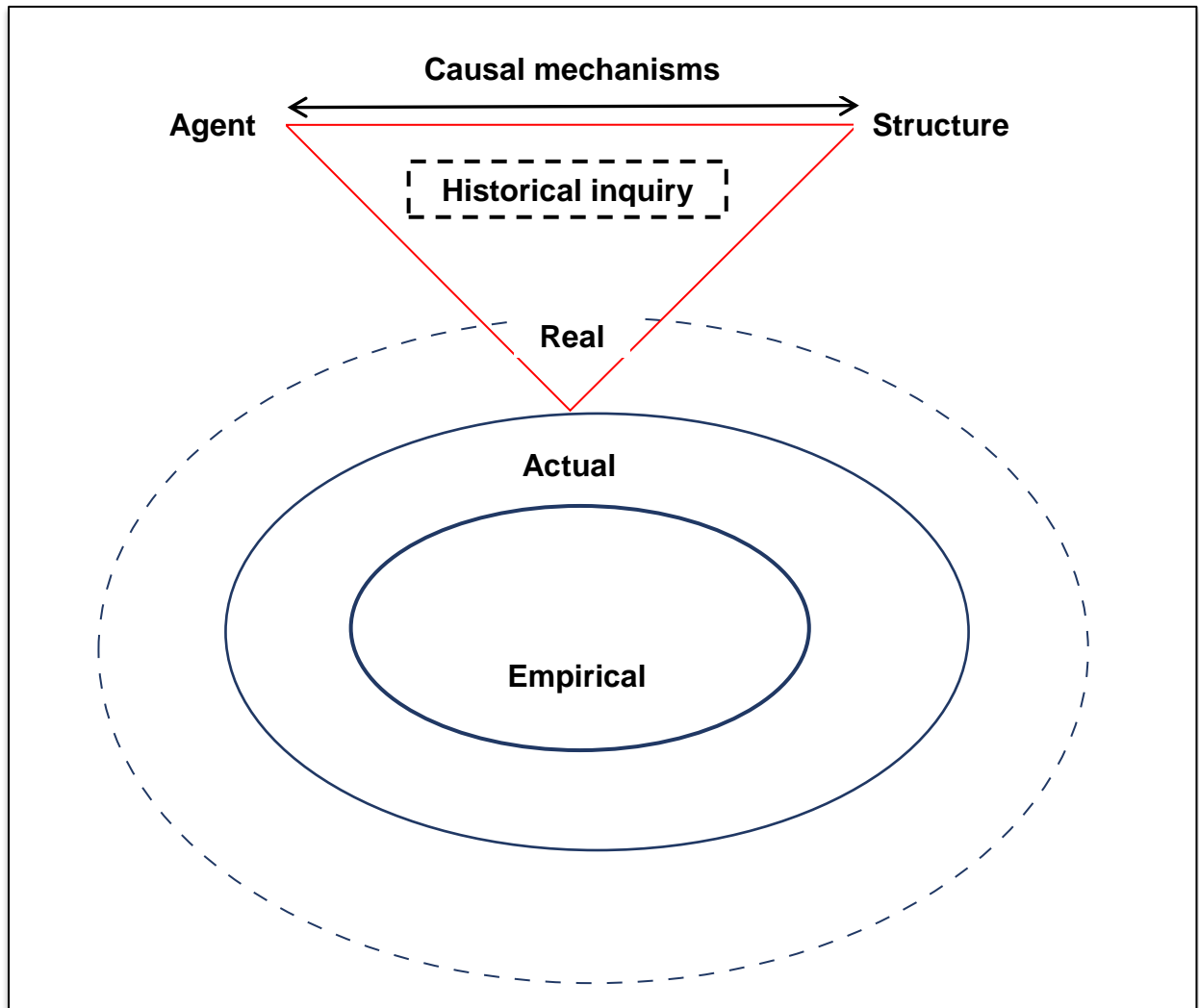


Figure 2.1 Historical inquiry searches for causal mechanisms in the real domain of critical realism
(Critical realism domains as illustrated in Schiller 2016:90)

2.3 CRITICAL REALISM IN SOCIAL STUDIES

Social complexity, represented by humans (nurses), changing organisational structures (e.g. SANA to DENOSA) and power relationships between organisations (e.g. the Medical Council and SATNA) make it difficult to recognise, understand and explain the true nature of organisational interaction. Some aspects of the complex and dynamic power relationships that influence the reciprocal relationship between humans and organisations

are evident, while other aspects might be hidden and thus go unnoticed. The hidden and observed aspects respectively represent the real (the hidden causal mechanisms) and the actual (the observed/not causal mechanisms) domains of critical realism (Herring & Stokes 2011:11). Critical realists are primarily concerned with illustrating how causal mechanisms influence all three of the reality domains (Fletcher 2017:183). It is the task of the researcher in this thesis to present a plausible interpretation (Herring & Stokes 2011:11) of the causal mechanisms that historically influenced the nature of nursing organisations, which in turn influenced the professional development of South African nursing.

In applying the philosophical concepts of critical realism, the researcher deduces that nursing organisations are socially significant causal structures. Roles of authority are bestowed. The resultant power relationships and social interactions all transpire within visible physical dimensions (Edwards, O'Mahoney & Vincent 2014:4). The interaction between social structures and power relationships creates emergent properties, and although relationships and physical dimensions change over time, organisations endure and continue to act as causal powers. The longevity of successful organisations results in slow, sometimes unnoticed influences. Historical inquiry is valuable in noticing those slow developing changes, as it provides a sequential explanation of how, over time, (nursing) organisations influenced the (nursing) profession and society itself. It enables the identification of causative mechanisms (Edwards et al 2014:2-4; Lonergan 1970:240-241). This thesis examines the causative mechanisms that influenced the development and consequent nature of professional nursing organisations, as well as their influence on the South African nursing profession.

A person is restricted in behaviour by the structural factors surrounding him or her (Clark 2012:3). The transformational model of social activity, which states that there is a reciprocal connection between human agents and social structures (Herring & Stokes 2011:11-12; Roberts 2014:5), creates awareness of such connections being present in the history of professional nursing organisations. Social constructs such as the role of women in 19th-century society, and consequently the position of nurses, historically influenced health-care structures and relationships. Over time, professional nursing organisations assisted in altering these accepted social constructs – and thus the profession. For such reasons, critical realism declares that although a hermeneutic

understanding is important, understanding the hidden but causative structures and relationships is equally important (Benton 2011:3; Elger 2012:3).

If organisations are viewed as causative social structures, then different explanations about those structures become possible and the research attains ontological depth (Herring & Stokes 2011:12). To analyse why/how organisations obtained their power to influence, it is important to observe these structures' unique characteristics (Elder-Vass 2015:82). For example: by identifying the unique characteristics of a powerful nursing organisation, its influence on the professional development of nursing in South Africa can be explained. However, one set of criteria should be used to assess the characteristics of all South African nursing organisations – or else each nursing organisation's unique influence will not become evident. Judging the causal power of each organisation will not be possible as there is nothing to compare it with.

2.4 LONERGAN'S COGNITION STRUCTURE APPLIED IN HISTORICAL INQUIRY

Walker (2017:113-115) argues that the philosopher Bernard Lonergan's Transcendental Method, which explains how human beings structure cognition, is a form of critical realism. Lonergan (1973:17-18; Walker 2017:115) states that an experience (level 1) transforms into understanding (level 2) which in turn becomes a judgement (level 3). Only if judgement has been reached can objects of thought become objects of judgement.

Figure 2.2 illustrates how the three levels of Lonergan's cognition structure complement the historical inquiry. The black arrows indicate the flow of the critical realism process, while the red and blue rectangles illustrate the corresponding phases of historical inquiry. This diagram, which has critical realism as primary focus, should be viewed in conjunction with Figure 3.2 in Chapter 3, which has historical inquiry as primary focus.

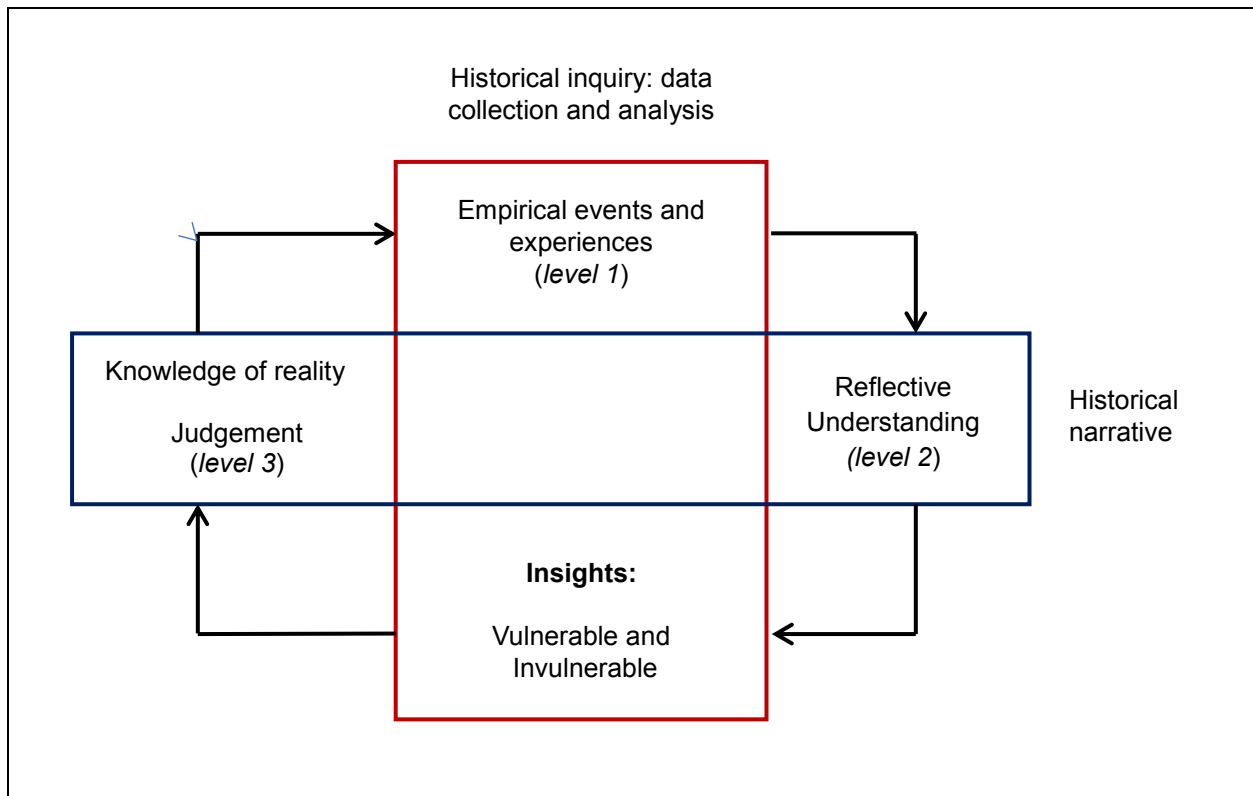


Figure 2.2 Lonergan's cognition structure complements historical inquiry

(Lonergan 1980:222-223; Walker 2017:113-115)

Lonergan (Walker 2017:115) claims that knowledge is more than only what can be observed with our senses (the empirical). A person (researcher) who had the experience (level 1) of observing something inevitably asks questions about *what* it is he or she observed and *why* it happened. Attempts are made to understand (level 2) the event and acquire insight. If a person (researcher) has gained insight, a judgement (is it true?) about and a concept definition of the event can be made. Only after a judgement (level 3) has been made, can a person (researcher) claim that ideas and thoughts became knowledge.

When applying Lonergan's (1980:222-223) cognition structure to the thesis, it can be argued that historical inquiry is about more than merely recording historical events. The inquiry should reach a knowledge level, with the researcher not only asking *what* happened (experience – level 1), but also inquiring *why* (understanding – level 2) the historical event happened. To illustrate: although it is important to provide a historically accurate description of *what* happened during the 1942 trade union crisis, it is even more important to ask *why* it happened. The answer to the *why* question allows a deeper understanding of how multiple structures and agents interacted to create a unique historical event which influenced professional nurses as workers in South Africa for more

than 50 years. In critical realism terms, this attainment of a deeper understanding is referred to as reflective understanding (Lonergan 1973:23-24; Walker 2017:115).

If correct judgements are made, the researcher attains insight and a knowledge of reality. Sometimes one's initial insight must be changed because there might still be some questions that need to be asked and answered. This initial insight is often evident at the beginning of a study and is referred to as a *vulnerable* insight. If all possible questions have been asked and answered, an *invulnerable* insight is obtained (Roberts 2014:2; Walker 2017:115-116). This philosophical underpinning made it important for the researcher to ask many questions during the data analysis phase to ensure that historical data and the context in which they occurred was understood correctly (note Chapter 3, sub-section 3.4.1.4). These questions were asked from various viewpoints, allowing new answers to emerge. Numerous vulnerable insights were attained in this manner. To illustrate: the historical outcome of the 1942 trade union crisis was statutory independence for South African nurses (in the form of SANC) and compulsory membership of a single professional nursing association (SANA). By asking questions about the reason(s) for the compulsory SANA membership, new insight was gained. It became evident that the decision about compulsory membership of the nursing association might not have been made solely on ethical and moral grounds (nurses should not strike), but also to protect trained nurses against the perceived unfair competition of untrained and un-registered nurses who were practising at that time (only trained, SANC registered nurses could join SANA and practise nursing).

While the data analysis and reflection phases of the research (Chapters 4-8) contain the vulnerable insights, the invulnerable insights were attained when it became evident that there were no more questions to ask which would lead to new insights. A state of objectivity was reached (this critical realism concept supports the qualitative research principle of crystallisation discussed in Chapter 3). The invulnerable insights are discussed in the Conclusions chapter of the thesis.

Some complex historical events might not have definite answers (invulnerable insights). In such incidences, the nature of historical events, and not only the facts, become important. To illustrate: while exploring the nature of nursing organisations in the 1950s to the 1980s, it was important to understand the thoughts and/or discussions that were conducted at that time. Within such contexts, secondary historical sources (e.g.

newspaper articles and nursing journals) were considered important, as the article content illustrates the types of discussion that nursing organisations and society held about the impact of politics on the profession – leading to that which is recorded in primary sources (such as minutes of meetings). Sociologists refer to this ability of “linguistic devices” (Edwards et al 2014:16) such as journals to influence social and organisational action (recorded in primary sources) as the *linguistic turn*. A historical narrative therefore attempts to explain historical outcomes by analysing the interplay between critical realism’s real, actual and empirical domains (Edwards et al 2014:16, 22, 24).

2.5 THE COMPLEXITY OF AN OPEN SOCIAL SYSTEM

In this section the researcher discusses the open social system envisioned by critical realists and explains how this philosophical belief influenced the historical narrative.

2.5.1 An open social system has many influencing structures and relationships

Human accounts of how organisations historically caused change can only be reflective and interpretive in nature, and lead to the assumption that one can never control all the causative structures and relationships. The difficulty of an open social system as envisioned by critical realists becomes evident. Critics ask to what extent such a system, with its complex and many influencing structures and relationships, can be examined (Benton 2011:3; Elger 2012:3-4). Critical realists reply that complexity must be embraced, explored and explained. The focus is on the reconciliation of the real domain with the actual domain so that phenomena can be explained in the context of the real world (Clark 2012:3). For these reasons, the researcher must explore all agency and structural factors evident to provide rich, all-embracing explanations of historical events. By using diverse types of data such as minutes of meetings; conference programmes and photographs from nursing journals, the complexity of data patterns and their arrangements becomes evident. Rich, sweeping explanations assist in explaining intricate interactions between agents and structural factors. Elger (2012:7) refers to this process as the “theoretically led, non-empiricist account of knowledge production”. It is therefore imperative that key sources (primary sources) and data be sampled and analysed until saturation (crystallisation) occurs (Clark 2012:4-5). Chapter 3 of this thesis includes a comprehensive discussion about the use of primary sources and the concept of crystallisation.

Critical realists (Elder-Vass 2015:82) declare that a researcher's awareness of the phenomena of interest (e.g. South African nursing organisations) implies prior knowledge about at least a fragment of that complexity called society. It is then also possible that a researcher forms specific assumptions about the causal powers involved in the phenomena of interest. Elder-Vass (2015:81-82) and Fletcher (2017:183) suggest that it is therefore best to start with a process called *retroduction*: a researcher first acknowledges the already identified causal structures and the circumstances that produced and enabled their powers. Thereafter the unique combinations of causal powers that were involved in a historical event are described (a process called *retrodiction*). In this thesis, the researcher probably has pre-existing assumptions about the causal powers that historically influenced the nature of nursing organisations and by extension the nursing profession. The factors and mechanisms that led to the establishment of professional nursing organisations as causal powers were identified first. Thereafter the interaction between professional nursing organisations and other causal powers was explored to explain how this influenced the development of professional nursing in South Africa.

Critical realists state that there can be no absolute truth, but rather a well-considered interpretation of evidence. Reality is complex and our knowledge about it provisional. Although it is possible to discover knowledge about reality, such knowledge can never be considered absolute. New questions lead to new understanding and insights and therefore new knowledge (Burgoyne 2011:4; Elger 2012:3; Walker 2017:117). This philosophical view can be applied to historical research projects, as the researcher's conclusions depend on the availability and reliability of historical data and the accurate contextual presentation of that data. Similarly, the researcher's position within (not separate from) society implies that "experimental closure" is never possible in social research (Benton 2011:2-3). These assumptions imply that the interpretations of the researcher and other nursing history enthusiasts must be based on evidence (primary and secondary sources) and can be considered to hold elements of truth, but never the ultimate truth (Lonergan 1980:384-385). Critical realists and historians agree that this kind of research will always lead to debate (Fletcher 2017:188; Walker 2017:121).

2.5.2 The relationship between structure (culture) and agency (organisations) creates a framework for social interaction

From an ontological point of view, structure and agency are separate but interdependent entities (Benton 2011:4), as they both autonomously wield causal influences (referred to as analytic dualism). Both these entities are subject to emergence over time (Edwards et al 2014:4-5). When the effects of causative mechanisms within a unique social context are interpreted, the concept of culture should be viewed as a structure that enables and/or constrains agency. It is therefore important to consider the changes in the relationship between structures and agents, as they created the framework in which social interaction between agents occurred (Benton 2011:4; Edwards et al 2014:5). If social structures are viewed in this way, different explanations about those structures can be considered and judged. Critical realism therefore creates three levels of social reality: namely, what we claim to know about reality; social reality as it currently exists; and a potential social reality (Herring & Stokes 2011:18).

Elger (2012:3-4) states that culture must be considered as one of the interconnecting structures of social interaction. Any conversation about culture should demonstrate ontological depth by referring to how that structure (culture) within a specific time context (historical) played a role in constraining and/or enabling agencies (in this case nursing organisations). This ontological point of departure influences how interactions between structure, agency and culture are studied. Critical realists use what Margaret Archer (Edwards et al 2014:4-5; Zeuner 1999:79-80) calls the morphogenetic approach to examining how structure and agency interact over time. The morphogenetic approach avers that a given structure (e.g. culture) conditions social interaction but does not determine it. Rather, social interaction originates from other social agents, which in turn lead to structural elaboration or modification. Morphogenesis is therefore defined as the change in the relationship between the parts.

South African professional nursing organisations and their interactions with societal agents are examined because this explains the influence that these organisations had on the nursing profession. In this thesis, one of the most difficult tasks was to explain within a historical context SANA's apparent participation and/or support of the South African government's segregationist legislation after the Second World War (WWII). The researcher used the morphogenetic approach to guide the inquiry of how socio-cultural

value systems (structure) interacted to create a unique set of socially determined and legislative rules with which South African nursing organisations (agencies) were expected to comply. Those in power can suppress change for a while, but eventually change will happen, leading to socio-cultural modification. Over time, cultural interaction led to changes in nursing organisations' policies and activities. Over time, periods of morphostasis (before the political changes of 1994: no change in the relationship between the parts) and morphogenesis (after the political changes of 1994: change in the relationship between the parts) became evident. The morphogenetic approach therefore facilitated the researcher's efforts to illustrate how nursing organisations (agencies) changed over time and consequently how socio-cultural modification in the nursing profession itself occurred.

2.6 SUMMARY

Critical realism philosophy avers that veiled, unobserved structures and relationships in the real domain have influence on world events. This philosophical underpinning facilitates the search for unobserved structures and relationships that influenced historical events. In the next chapter the research methodology, historical inquiry, is discussed in detail. That chapter will also explain how critical realism was applied in the research.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In Chapter 2 the philosophical framework of the research was discussed. The chapter explains why and how critical realism is a suitable choice as a philosophical underpinning when conducting historical inquiry.

While Chapter 1 of the thesis provided a brief overview of the historical inquiry process, this chapter contains an in-depth discussion of the research methodology. The research design, trustworthiness and the ethical dilemmas that historians must consider are discussed. The chapter concludes with an explanation of how the chosen philosophical framework complements the research methodology.

3.2 RESEARCH DESIGN

Historians spend time and effort in trying to understand how past events influence the present. Their primary focus is not so much on recording dates, events and persons involved, but rather on what *meaning* historical events have for contemporary society. Historical inquiry is therefore the study and interpretation of historical events, with the aim of explaining the influence these events exert on present and future societies (Brundage 2013:3-4; Fitzpatrick 2007:377-378; Francis 2013:56-57, 63; Freathy & Parker 2010:233; Gaddis 1995:8).

The value of historical inquiry lies in its ability to inform and influence. Historical inquiry requires critical reflection, enhances reasoning skills and challenges traditional beliefs. It can generate empathy, tolerance and, most importantly, provide insight into current policy and practice by identifying economic, political, social or cultural factors of influence. Historical ignorance causes contemporary society not only to repeat past mistakes, but even to misrepresent historical facts to serve a particular agenda (Freathy & Parker 2010:233-234; Sweeney 2005:64). In contrast, historical awareness calls attention to long-term ideological trends that are present in a society and that only become evident if

that society's history is studied. Historical awareness enables the living to consider and recognise behavioural patterns that become evident over time. It explains how the past influences the present (Babbie 2013:314; Freathy & Parker 2010:233; Gaddis 1995:22). In this study the researcher, informed by critical realist philosophy, explored the history of nursing organisations in South Africa to identify the factors that influenced the development of these organisations and their influence on the development of the profession.

One finds numerous and diverse explanations of the concepts history, historiography and historians. Austin (Streubert & Rinaldi Carpenter 2011:226; Sweeney 2005:63) explains that history is "an integrated written record of past events, based on the results of a search for the truth", while historiography is "a synthesis, building into a related whole, of facts which have been verified". A historian is defined by Christy (Sweeney 2005:63) as a person who studies and teaches history, while a historiographer records history.

From these definitions, it becomes evident that historians carefully interpret reliable historical sources and provide reasonable explanations of why historical events occurred and how they influenced society. The historian's conclusions can only be valid and reliable if the interpretation of events was done with an in-depth knowledge of that historical period, and by considering the context in which the event occurred. It also implies that a historian's interpretation of events is open to criticism (Brennan 2011:661; Gaddis 1995:25; Galgano et al 2008:1-3). Not all questions (only the research objectives) can be answered in a study, and any historical inquiry thus contains vulnerable insights. Structures and agents are influenced by multiple causal mechanisms. Depending on the data analysed and the researcher's interpretation of such mechanisms, multiple truths become possible. The possibility of multiple truths implies that other researchers might have different interpretations of historical events, which leaves the findings of the study open to criticism.

The historian's reliance on written documents (objective data) to interpret (thus implying subjectivity) the meaning of an historical event requires reflection on matters pertaining to the ambiguous ontological and epistemological nature of historical inquiry.

3.2.1 Historical inquiry's ontological and epistemological ambiguity

Qualitative research is a naturalistic approach, which requires that a human act as the research instrument (Lincoln & Guba 1985:187; Streubert & Rinaldi Carpenter 2011:89). Qualitative research findings are subjective (interpretive), not measurable and non-transferable in nature. Ontologically, this implies that deeper meaning about our complex world and life in general is revealed by mankind's fallible description thereof. Qualitative researchers support an epistemological emerging worldview, which holds that knowledge and truth are obtained by studying other people's lived experiences. This implies a certain measure of subjectivity (interpretation) and involvement with the research participants by the researcher (Gibson & Brown 2009:82; Graneheim & Lundman 2004:106; Nieuwenhuis 2010a:50-56; Rolfe 2006:306). Critical realists hold a similar view about the subjective position of the researcher within the research (Benton 2011:2-3).

Although the researcher's involvement with human research participants was not a concern due to the use of nursing literature and archival material, her involvement in the field of study as a practising nurse had to be considered. The nature of the data sources required the interpretation of historical documents, thereby introducing an element of subjectivity into the study. The researcher read and reflected on factual data such as books, nursing journal articles and minutes of meetings. The researcher then described her interpretation of the data in a historical narrative, which placed professional nursing organisations within the broader South African context. Clearly, any findings about professional nursing organisations and their influence on South African nursing are unique to this country and cannot be transferred to professional nursing organisations elsewhere in the world.

Historical inquiry is classified as a non-traditional, qualitative research design (Nieuwenhuis 2010b:70-71; Polit & Beck 2014:273). It is not a rigidly applied research method, but rather an ambiguous research style which incorporates a range of methodological approaches to discover plausible answers to historical questions (Fealy, Kelly & Watson 2013:1882; Freathy & Parker 2010:232). Historical inquiry requires the researcher to study factual data (evidence of positivism), interpret the data (evidence of subjectivity) and come to a plausible non-transferable conclusion (interpretivism). Gaddis (1995:14) declares that a historian must "plant oneself firmly in that large but ill-defined middle ground that separates the rootlessness of relativism from the inertia of

objectivism". Historians and critical realists concur that such a large, ill-defined middle ground (reality) implies that multiple truths are possible (Fletcher 2017:188; Francis 2013:57; Lincoln & Guba 1985:224, 295).

Although a qualitative research design such as historical inquiry has elements of positivism, it requires unique validity criteria and cannot be evaluated within a quantitative mind set (Babbie 2013:319; Gaddis 1995:24; Galgano et al 2008:3; Rolfe 2006:305).

3.2.2 Historical inquiry methodology

Historical inquiry was conducted to explain how professional nursing organisations influenced the development of the South African nursing profession from 1914 to 2014. The findings of the research were documented, and an effort was made to confirm that the unique histories of these organisations created an independent, recognisable professional presence, with the potential to assist in the professional socialisation of nurses.

To those inclined to conduct quantitative research, historical inquiry as a research methodology appears unstructured and disorganised. The naturalistic (qualitative) researcher works with an emerging design using an open-ended, inductive data analysis strategy (Brink, Van der Walt & Van Rensburg 2012:121; Lincoln & Guba 1985:224; Streubert & Rinaldi Carpenter 2011:74). Lincoln and Guba (1985:225) discuss the nature of naturalistic inquiry and state that "perhaps the only thing the naturalist can be sure of is that there will be slippage in whatever plans are made".

Yet, historical inquiry is not totally without structure – rather it is a cyclical process with specified phases of inquiry which may be completed in any order (Lewenson 2008:26; Streubert & Rinaldi Carpenter 2011:230). In the researcher's previous use of this methodology (Esterhuizen 2012:17), the steps of historical inquiry were illustrated by using double arrows to denote its cyclical, repetitive nature (note Figure 3.1). Reflecting on this earlier attempt, the researcher modified her understanding and the schematic illustration of the historical inquiry process. An explanation and the subsequent adjustment of the illustration (note Figure 3.2) follows below. To enable a comparison between the researcher's 2012 (the "old") and current (the "new") understanding, the current study topic, namely professional nursing organisations, is used. The researcher's

prolonged engagement with the research methodology enhances the trustworthiness of the thesis.

3.2.2.1 The researcher's previous understanding of historical inquiry

Figure 3.1 illustrates the historical inquiry process as used and understood by the researcher in earlier research (Esterhuizen 2012:17). Following the diagramme, the steps of historical inquiry are described with the application thereof on the *current* research topic stated in brackets.

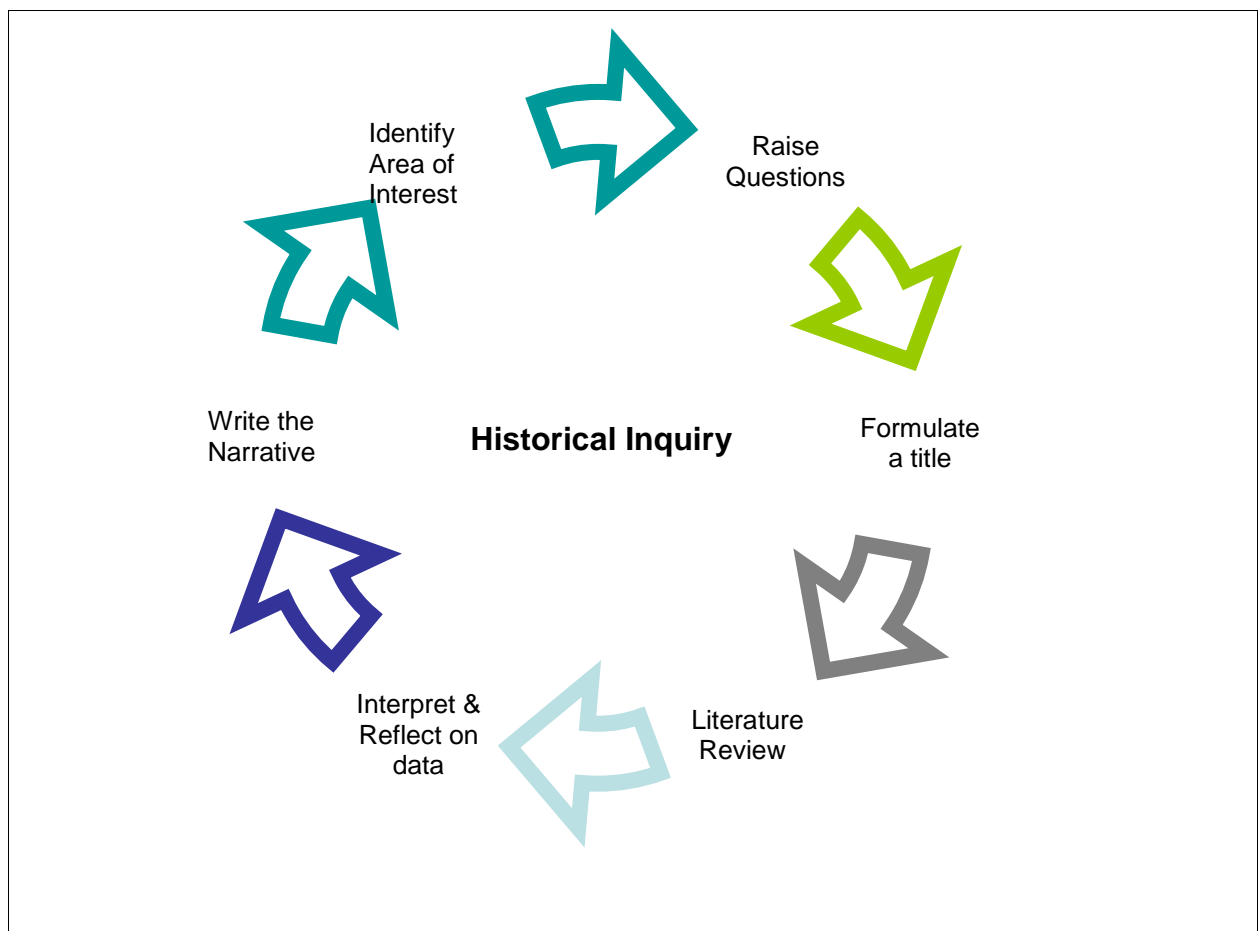


Figure 3.1 Schematic representation of the historical research process
(Esterhuizen 2012)

Lewenson and McAllister (2015:7-14) explain the phases of historical inquiry, which commence with the researcher identifying an area of interest. Once such a broad area of interest had been identified (in this thesis: professional nursing organisations in South Africa), the researcher asked questions that assisted in narrowing down and specifying the area of interest (What types of professional nursing organisations are evident? What

influence did they exert on the profession? What historical events enabled professional nursing organisations to exert a continued influence on the development of South African nursing?). A title was formulated (“The influence of nursing organisations on the development of the nursing profession in South Africa 1914-2014”), which directed the researcher to conduct a literature review. The initial historical data collected and interpreted stimulated the emergence of other questions, which in turn could only be answered by continuing with the literature review. Data thus collected was reflected on, interpreted within the appropriate social context and finally recorded. Data collection, analysis and writing the narrative therefore occurred simultaneously, but were performed more than once (Barroso 2010:114-115; Gaddis 1995:11; Galgano et al 2008:42; Lewenson 2008:27-40; Sweeney 2005:65). The cyclical nature of historical inquiry became evident as a continuous in-depth literature review was done and sub-themes (in this thesis: the periods dominated by SATNA, SANA and DENOSA respectively) identified. The researcher concluded the study when crystallisation occurred: all influencing factors were identified. The researcher applied bracketing (omitting potential biases) during this cyclical process. (Also, note subsection 3.3.3 of this chapter).

3.2.2.2 The researcher’s current understanding of historical inquiry

A historian’s narration of historical events depends on the use of data-rich sources and the researcher’s interpretation thereof. It implies that the result of the historian’s endeavours is nothing more than an informed interpretation of accessed historical data (Sweeney 2005:65, 71-77; Taylor & Francis 2013:58). The interpretation and understanding of historical events can change if new, reliable data sources that shed a different light on the topic are discovered. It is the historian’s duty to ensure that the historical interpretation is meaningful and that it is presented in an acceptable context (D’Antonio 2008:19-20; Galgano et al 2008:2-3; Lewenson 2008:39-40). This description of historical research confirms the statement made by Francis (2013:57) that historians have an interpretivist research view: that there is no absolute truth and that historians accept the existence of multiple realities and truths. Historians’ work is always subject to revision by other historians (Gaddis 1995:25), because critical realism allows that multiple truths are possible (Fletcher 2017:188; Walker 2017:121).

Theoretically speaking, historical inquiry can be viewed as a prolonged, even life-long, search to find the historical truth. The historical inquiry cycle used in the researcher’s

previous study (as depicted in Figure 3.1) with its continuous nature, illustrates that. At the beginning of the research, the researcher implemented the historical inquiry cycle used in a previous study, but realised that the research project must conclude once crystallisation was reached. It is therefore not possible to remain in the continuous, never-ending historical cycle suggested in Figure 3.1.

Another issue that had to be considered was the fact that the thesis's main topic of interest had been identified and approved by the university's Research Ethics Committee during the proposal phase of the research. The topic of interest did not change during the data collection and analysis phases. An interim title guided the literature review and the questions asked, leading to the identification of sub-areas of interest (e.g. the influence of the 1942 trade union crisis on the formation of SANA) and ultimately crystallisation. Once crystallisation was reached (in critical realism terms: once the causal mechanisms were identified and invulnerable insights related to the research objectives obtained), the narrative was written, and the research title finalised.

A formal historical inquiry research project (such as a doctoral thesis) is limited in terms of time, resources and scope. It must conclude with a written narrative after enough time has been spent on data collection and analysis. The researcher's 2012 illustration (Figure 3.1) of the historical inquiry had to be reconsidered (illustrated in Figure 3.2) to accommodate the limited (not a life-long search) nature of a thesis:

- Two steps of the cyclical process were repositioned: the first step (identifying the main topic of interest) was done once only and the last step (finalising the title) brought an end to the study. This is illustrated in the diagram with arrows.
- During the research, the cyclical process of historical inquiry only holds true *within* the main topic of interest: the main topic did not change, but within it new sub-areas of interest arose and became the chapters of the thesis. This is illustrated by the smaller circle in the diagram.
- The role of crystallisation in signalling the end of the data collection and analysis phases was added.
- Completing the thesis did not imply that research about the topic of interest was complete. Questions about the findings of this research and its implications might lead to further research (the life-long search previously mentioned). The larger circle in the diagram illustrates this aspect.

- The larger circle in the diagram is represented by a broken line to illustrate the real domain as defined by critical realists. The world is an open system, with knowledge yet unknown (note Chapter 2, Figure 2.1).

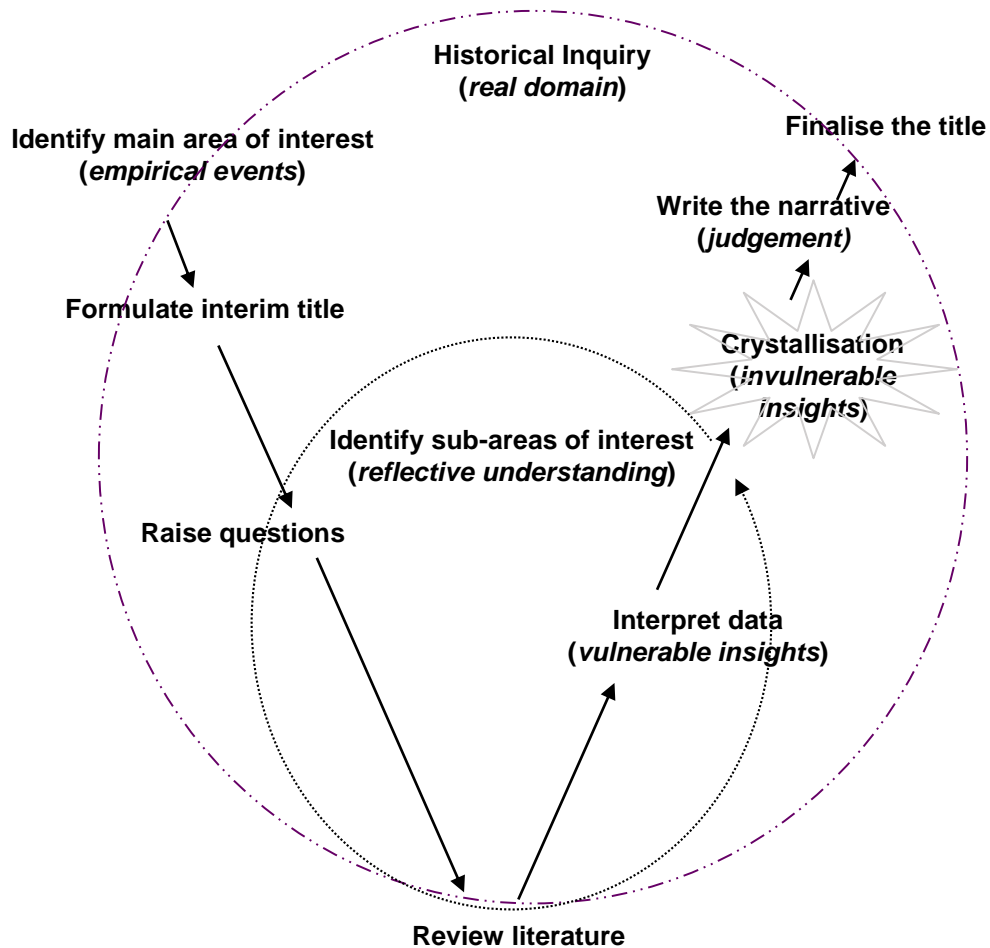


Figure 3.2 The researcher's current understanding of historical inquiry methodology
(The complementary critical realism terms are in italics.)

3.2.2.3 Critical realism informs historical inquiry

The researcher's changed understanding of historical inquiry methodology and the corresponding critical realism concepts are illustrated in Figure 3.2 (also note Chapter 2, Figure 2.2).

In Table 3.1, Fletcher's (2017:184-186) discussion about the application of critical realism in research methodology was used to illustrate how critical realism informed the historical inquiry.

Table 3.1 Critical realism applied to the research methodology

CRITICAL REALISM (philosophy)	HISTORICAL INQUIRY (methodology)
<i>Critical realism sets the parameters of possibility for the historical inquiry</i>	
Research objectives	
Identify causal mechanisms	<p>Explain the factors that influenced the development of South African nursing organisations evident from 1914 to 2014</p> <p>Explain how nursing organisations influenced the professional development of the South African nursing profession</p>
Data collection	
Find empirical data	Thick descriptions of historical data using primary and secondary sources
Data analysis (abduction)	
<p>Search for demi-regularities</p> <p>Obtain vulnerable and invulnerable insights</p>	Reflective reading of historical sources
<i>Interpret (historical) events</i>	
Data analysis (retroduction)	
<p>Find causal mechanisms</p> <p>Identify social conditions that facilitate causal mechanisms' activities</p> <p>Identify social tendencies and the relationships that makes them essential</p>	
<i>Provide a fallible explanation and analysis of historical (social) events</i>	
<i>Identify causal mechanisms to inform social change</i>	
<i>Suggest social change and/or policy recommendations</i>	

(Adapted from Fletcher 2017:184-186)

3.2.2.4 Historical inquiry's methodological weaknesses

The greatest challenge for those who attempt an understanding of history is a phenomenon referred to as presentism: modern society tends to judge past generations' actions by using modern-day values and preconceived ideas about the past as their moral

compass (Galgano et al 2008:4; Streubert & Rinaldi Carpenter 2011:228; Taylor & Francis 2013:56-57). The historian must always be alert to the fact that presentism is a state of knowing which influences historical interpretation. Thus, a conscious effort must be made to identify with the era and the society being studied (Brundage 2013:24; Sweeney 2005:64). Presentism should not provide the answers to historical questions (Gaddis 1995:18).

Time to travel, accessing archives and finding documents relevant to the research topic makes historical inquiry expensive. In contrast to those using quantitative studies, historical researchers are unable to state at the beginning of their research projects how much time and travel will be required – and indeed exactly what they will do and/or find (D’Antonio 2008:16; Lewenson & McAllister 2015:17; Sweeney 2005:72; Taylor & Francis 2013: 60). The historical researcher must be, if nothing else, flexible.

Another potential weakness to take cognisance of is the historical document itself: its authenticity, its purpose, its clarity. After all, the historical researcher was not there to witness the historical event at first hand. Rather, the researcher reads *someone else’s* first- or second-hand account of events (Lewenson 2008:34, 37; Sweeney 2005:65; Taylor & Francis 2013:61).

3.2.3 Research objectives

The researcher identified four research objectives. The first two objectives were to explain the factors that influenced the development of South African nursing organisations from 1914 to 2014 and to explain how changes in these organisations over time influenced the professional development of South African nursing. The third objective was to describe the professional, social, political and educational functions of South African nursing organisations and the factors which led to their professional growth and/or demise. The last objective was to illustrate the unique histories of South African nursing organisations, which created an independent, recognisable professional presence in South African society and assisted in the professional socialisation of nurses in South Africa.

3.3 RESEARCH METHODS

The following sections describe the literature review and explain the principles of data collection and analysis.

3.3.1 Finding data-rich sources

The aim of qualitative research is to acquire in-depth information about the research topic (phenomenon) and then address the research objectives. The importance of collecting reliable data must be discussed. In this thesis, all the literature related to the history of professional nursing organisations in South Africa was considered.

For this historical inquiry, the literature review included any form of the written word (be it electronic, books, photographs, minutes of meeting, speeches, policy statements or other documents) that explains the history of South African professional nursing organisations:

- primary sources available in online international archives, South African archives and private collections
- secondary sources available online and in libraries

Professional organisations serve as archivists and historians of the (nursing) profession (Babbie 2013:318; National Business Education Association 2010; Nieuwenhuis 2010b:73). This explanation holds true as DENOSA ([Sa]:10) states in its member guide booklet that one of the organisation's aims is "To achieve progress for nursing and midwifery in South Africa in ... the safeguarding of the historical heritage of the profession". Documents created and stored by professional nursing organisations contributed to creating a reliable historical context and were included as sources.

The researcher had to identify and include those sources that gave data-rich descriptions of the phenomena being investigated. Sweeney (2005:66) refers to the search for data-rich sources as "an exhaustive coverage of a wide range of documentary sources". Collecting such valuable sources provided the researcher with a greater opportunity to gain an in-depth understanding of past events. Only then could the appropriate historical context be provided during the writing of the narrative. The researcher's primary focus was to acquire an in-depth understanding of a specified historical period, namely the

influence of professional organisations in the development of the nursing profession in South Africa from 1914 to 2014. Generalisation of the research findings was therefore not the purpose, or even desirable (Brink et al 2012:139, 141; Lincoln & Guba 1985:202; Mapp 2008:309; Maree & Pietersen 2010:176, 178; Stommel & Wills 2004:302-303, 329). The historical development of professional nursing organisations in South Africa occurred due to specific influences and it cannot be assumed that international nursing organisations experienced the same. Rather, the researcher attempted to provide what Lincoln and Guba (in Stommel & Wills 2004:333) refer to as thick descriptions: providing the reader with comprehensive contextual descriptions of the research settings (historical events) so that the reader can decide if the research findings are transferable and/or generalisable to other settings. Cope (2014:90) uses the term “vividness” to describe such rich, thick descriptions.

Considering the historical inquiry process (note sub-section 1.3), the advantage of purposively selecting data sources was that the data-rich sources could be identified and included over time, as the data collection, analysis and recording phases developed. This also meant that the researcher was unable to determine or quantify the data sources that would be reviewed at the start of the research project. Rather, the researcher continued with the data collection process until all newly acquired data confirmed that which had already been read, interpreted and recorded. Only then did the process come to an end. This is referred to as crystallisation (Brink et al 2012:141; Lincoln & Guba 1985:202, 224; Mapp 2008:309-310).

Although the purposive selection process provided the researcher with the freedom to select valuable and informative sources, it had certain disadvantages. As stated earlier, it might not be possible to generalise the research findings, but this was not the purpose of this qualitative research project. The greatest risk was that at the end of the research the literature reviewed and included in the study might expose the researcher to accusations of bias (Brink et al 2012:141; Stommel & Wills 2004:303, 333). For example, the researcher might have selected and included data sources that supported the viewpoint of the majority, but omitted the inclusion of opposing, minority viewpoints. Intellectual honesty and civility must therefore be the hallmark of the historical researcher (Sweeney 2005:66, 68). Preventative, ethical measures such as bracketing and reflection are discussed at length in sub-section 3.5.

3.3.2 Data collection

Data collection refers to the act of gathering all the information that might assist the researcher to complete the research objectives. The data-collection process must be guided by the research objectives (Hargreaves 2008:40; Polit & Beck 2014:184, 193; Sweeney 2005:69). The qualitative researcher's primary goal with the data was not to reduce it to a statistical value, but to discover meaning by means of interpretation. Data collection methods were therefore chosen to be unobtrusive and naturalistic, using the *researcher* as the data collection instrument (Lincoln & Guba 1985:224; Nieuwenhuis 2010b:78-79; Streubert & Rinaldi Carpenter 2011:89).

It is precisely because the researcher was the instrument of collection that the principle of bracketing was applied during data collection. Mapp (2008:309) explains bracketing as “setting aside pre-judgement”, so that participants are not influenced. In this thesis, the participants in historical events were represented by the written word (recorded in documents) and thus the researcher could exert no influence. However, the researcher's preconceived ideas might have influenced which participants' historical account (data) was considered for collection and which were left on the archival shelf (Hargreaves 2008:36). Hence the need for bracketing.

Hargreaves (2008:40-41) suggests the use of Scott's strict criteria to determine which sources should be included or excluded from the study. The four criteria suggested are:

- Authenticity: fake, copy of – or the original document?
- Credibility: the reason the document was created – selective or distorted data?
- Representativeness: context – does the document “fit in” with material from the same period?
- Meaning: easy or difficult to derive meaning from the document?

Although data collection was unstructured, rigour had to be applied to the process: it is easy to become distracted by interesting but (to the research objectives) irrelevant data. Gaddis (1995:11) declares that “despite what some students tend to think, writing history involves more than just running a giant vacuum cleaner, scooping up all the documents in one's path.” Rather, the focus is to discover new knowledge and critique it in the light of what is already known (Polit & Beck 2014:273). The researcher systematically and

rigorously examined all potential sources and continued reading until information was repeated in two or more sources. Data collection was therefore an on-going event, with the researcher immersing herself in the historical phenomena. Finally, effective and accurate notes were made and catalogued on index cards and by using electronic software (Lewenson 2008:32; Sweeney 2005:68-69; Taylor & Francis 2013:57).

The researcher collected data from primary and secondary historical documents. Primary sources are documents written by persons who were alive at the time of the historical event and/or involved in the event itself. They are eyewitness accounts that provide first-hand descriptions of events. Some were written for publication, while others (such as diaries) might have been meant for private or restricted use. However, the historical researcher must ponder the nature of each primary source: the writer might have recorded events incorrectly or omitted facts altogether (Brink et al 2012:161; Brundage 2013:20). It might represent a very one-sided version of events, as the writer's bias influences the narrative. Primary sources might also be ambiguous in their description and do not necessarily contain an analysis of the historical event (Barroso 2010:114; Lewenson 2008:34; Taylor & Francis 2013:58). Critical analysis and consideration of primary documents was therefore essential (Brundage 2013:21-23; Lewenson 2008:34):

- The research's philosophical framework guided the sample selection and analysis.
- The researcher reflected on issues of methodology, including the limitations of historical inquiry.
- The data obtained from other sources was compared with that of the primary document.
- The historical context in which the primary source was written was considered.
- The authenticity of the primary source was taken into account.
- Attention was given to detail, so that a truthful version of events could emerge.

Secondary sources are another person's interpretation of historical events, and that author did not necessarily use primary data sources (Taylor & Francis 2013:60). Although secondary sources were not recorded by those alive and/or directly involved in the historical phenomena, they provided the researcher with a starting point. By reading the secondary sources, the researcher discovered what was said in general about the historical phenomena, and that about which the sources were silent. They provided

insight into events; they described the social, political and economic context and awakened an awareness of questions yet unanswered. The historical researcher therefore commenced with the reading of the secondary sources and created a research trial by keeping a comprehensive list of what was read. This list of secondary sources was updated regularly as new sources came to light (Barroso 2010:114; Brundage 2013:116; Galgano et al 2008:5, 20; Lewenson 2008:32; Taylor & Francis 2013:58, 60-61).

3.3.3 Data analysis

Historical inquiry's data analysis is not a distinctly recognisable phase. Rather, it is an arbitrary point in the much-repeated cycle of collecting data, reflecting on its meaning and, guided by the questions arising from such analytic reflections, collecting data again. In this way, vulnerable and invulnerable insights are obtained, and demi-regularities discovered (Fletcher 2017:184). The cyclical nature of the data analysis phase was supported by Lonergan's three cognition levels (note Chapter 2, Figure 2.2), which explains the fact that repeated and reflective reading of the data allowed the researcher to gain insight and knowledge of reality. Qualitative data analysis must be guided by the research objectives, which provide direction and purpose (Brink et al 2012:193; Nieuwenhuis 2010c:99-100).

3.3.3.1 *Applying a priori codes*

The qualitative researcher must devise some way of arranging and categorising the large volume of data that have been collected during the study. As soon as data collection commenced, the categorising process began. As the researcher developed a deeper understanding of the research phenomena, these preliminary categories at times changed (Brink et al 2012:193-194; Nieuwenhuis 2010c:104).

One method of arranging data, which also effectively assisted in providing historical context, was the use of *a priori* codes. *A priori* codes differ from inductive codes in that inductive codes emerge from the data, while *a priori* codes are determined before data analysis commences. Applying *a priori* codes to the art of historical inquiry demanded that the researcher use pre-set research categories (e.g. influential historical events) to collect data specific to each of the *a priori* categories. The value of arranging data in this

way was that it provided the researcher with a clear direction of what information to collect (hence the researcher's choice of non-probability purposive sampling) so that crystallisation (data saturation) could be reached. By implication, *a priori* codes influenced the narrative style of the research report (Fealy et al 2013:1890; Gibson & Brown 2009:132; Lincoln & Guba 1985: 201-202; Nieuwenhuis 2010c:107, 109). Lewenson (2008:40) confirms that the historical narrative can be written using an issue-based, a chronological or a biographical approach. The researcher used the issue-based approach by focusing on influential events in the history of South African nursing organisations.

The history of South African nursing organisations was divided into smaller areas of study by using flexible time periods, each of which is associated with the professional nursing organisation and/or a significant historical event that dominated that specific period. Using *a priori* codes allowed the researcher the flexibility to refer to other, lesser professional nursing organisations that emerged from the data. Thus, the researcher could give strength to the narrative by including all variables (D'Antonio 2008:11, 13).

Previous research (Esterhuizen 2012:30) taught the researcher that a willingness to be flexible about *a priori* codes is essential during historical inquiry. As information emerged from the data it became necessary to adapt, change or even abandon *a priori* codes that were used at the beginning of the research. The *a priori* codes changed because the researcher read archival sources and literature, reflected on the data collected and came to a new understanding and insight. Guided by critical realism principles, the focus of the study shifted from strictly applied time periods to events and causative mechanisms which significantly influenced nursing organisations (and hence the professional development of nursing) in a historical era. The adaptation of *a priori* codes illustrates the fact that the researcher's understanding of the historical phenomena and their meaning changed as she became immersed in the data (Gibson & Brown 2009:133-134). D'Antonio (2008:21) quotes Peter Novick who states that "trying to write history ... is like trying to nail jelly to a wall". At most, the use of *a priori* codes gave the jelly form.

3.3.3.2 *The research instrument*

Also guiding the historical inquiry's data collection and analysis was the research instrument, namely the researcher (Streubert & Rinaldi Carpenter 2011:89). The researcher being the research instrument implies involvement, not separation from the

social (historical) phenomena being studied. Critical realists (Benton 2011:3) accept this positioning of the researcher within society. The value of the human research instrument lies in his or her ability to utilise what Lincoln and Guba (1985:187, 195-198) refer to as tacit knowledge. Tacit knowledge is a way of understanding that which is difficult to explain, but essential to human (and thus the researcher's) insight into life's events. It forms the basis from which all deductions about human behaviour are made and can only be used by the human instrument. The instrument understands because he or she has experience of being human (Lincoln & Guba 1985:195).

The cyclical nature of historical inquiry implies that data collection, analysis and the writing of the narrative occur simultaneously, continuously and randomly. However, it is important to portray the historical time line and context accurately and truthfully. "[T]he art of contemplation, speculation and of interpretation" (Sweeney 2005:71) is required. The social history context and philosophical underpinnings of the study guided the search for data, and assisted with determining its inherent value and, finally, the judgements made (Lewenson 2008:15, 18, 26, 40; Sweeney 2005:64-65, 71).

3.3.3.3 Diverse types of documents create historical context

As stated earlier in this chapter (sub-section 3.3.1–3.3.2), the data sources of the study comprised any type of literature that shed light on the history of South African nursing organisations. Lincoln and Guba (1985:278-279) mention certain principles pertaining to the analysis of records:

- Assume that some form of record will exist for any event that happened.
- Being familiar with the functioning of society enables one to image the tracks that must have been left by the event.
- If the researcher is familiar with the world of records, he or she will know where to start looking for such tracks.

Once the historical documents have been found, Babbie (2013:318) suggests that the researcher asks the following questions about the documents:

- Why was it written? Who was the author?
- Is there evidence of bias in the document?

- How much time passed from the event being witnessed until it was recorded?
- What historical question does the document answer?

The value of newspapers is that they offer the reader a variety of views about current affairs and access to persons (e.g. political leaders) who might otherwise not be accessible to the researcher. It is, however, noteworthy to remember that newspapers do not represent an unbiased view of matters and they tend to sensationalise an issue. The researcher can also not be sure who the source of the information was. Newspapers were therefore not considered as primary sources, but rather as documents that assisted with the development of an in-depth understanding of events (Gibson & Brown 2009:74-75). Lincoln and Guba (1985:279) are not too concerned; they declare that potentially all data sources have some form of factual inaccuracy or misrepresentation and warn the researcher to be always vigilant.

Diaries on the other hand are primary sources, as the researcher can discover facts, previously unknown, of the writer's life and views. Herein lies the historian's dilemma: should these previously unknown facts be made public? It is suggested that permission should be obtained first (Brundage 2013:20; Gibson & Brown 2009:74). In this study, only one diary, on public display in a museum, was accessed and used. It was not possible to ask permission from the late author. The researcher reflected and concluded that the one reference from the diary could be made public without harm to the author's reputation or social standing.

Photographs, maps and drawings are powerful illustrators of a historical period. However, the researcher has to make sure that the image is representative of the truth – that it effectively explains the historical context. Photographs (e.g. the 100-year state registration commemorative coin) and scanned documents (e.g. letters from archives) were used to illustrate parts of historical events that might otherwise have been difficult to explain. They support and add value to the narrative (Gibson & Brown 2009:81-83).

Other forms of documentation such as letters, e-mails and online documents are important from the social research point of view. Gibson and Brown (2009:74) acknowledge electronic, online data as a valid documentary source, but unfortunately these types of documents are not always reliable. They can be moved on a web site, removed from a web page or altered by hackers. The authors might also not be evident

from the text (Gibson & Brown 2009:79-80). The researcher limited this type of data source to scanned historical documents from acknowledged, credible online archives such as that of the University of the Witwatersrand and historical journals available on the UNISA library's e-resources.

3.3.3.4 *Historical context within data sources*

It was important that the researcher considers the potential value and/or limitations of each type of literature (critical realism's linguistic devices) that might have triggered a linguistic turn and influence organisational action (note Chapter 2, sub-section 2.4). Due to the diverse nature of the primary and secondary sources used in this study, a short checklist (note Annexure B) to assist with the analysis of each source was required. Gibson and Brown (2009:72) refer to such a checklist as a record sheet and suggest that the following be included:

- Section 1: broad questions asked of all historical documents
- Section 2: questions specifically asked of this document
- Section 3: new questions arising from reading this document

Similarly, Galgano et al (2008:42) suggest that the following questions assist the researcher to find historical context in data sources:

- Who are the significant participants in the historical event?
- What was their response(s) to the event?
- Are there factors that conditioned this response?
- What are these participants' values and beliefs?
- What were the economic, social and political systems of the time?
- To what extent did ethnicity, class and/or gender matter?
- At the time, what other historical influencing factors were evident?
- How did these historical influencers affect the groups/persons involved?

The researcher used the above-mentioned guidelines to create the checklist evident in Annexure B. These guidelines provided the researcher with a valuable tool that directed data analysis, so that the research narrative and findings could be placed within an

acceptable and reliable historical context. As confirmed by critical realists (Elger 2012:7), the use of diverse types of data reveals the complexity of data patterns and their arrangements. Rich, sweeping explanations assisted in explaining intricate interactions between agents and structural factors.

3.4 THE TRUSTWORTHINESS OF THE RESEARCH DESIGN

The qualitative, non-traditional nature of historical inquiry required that the research setting, or data, not be controlled by the researcher. A naturalistic approach, where the data can speak for itself, was supported. The purpose of this study was to explain the factors that influenced the development and nature of nursing organisations and the contribution these organisations consequently made to the professional development of South African nursing in the period 1914 to 2014. An in-depth study of the literature generated knowledge and understanding of how the events of the past shaped the nursing profession of today. Knowledge and understanding of the past can also guide decisions about the profession's future (Francis 2013:63).

The research was qualitative in nature and required the researcher to be involved in the research (note sub-section 3.3.4), being the human data collection instrument (Cope 2014:90). Subjectivity and the risk of bias were implied, and it was therefore essential to implement measures to establish trust in the research findings and so confirm that the historical truth was recorded.

3.4.1 Measures to confirm trustworthiness

Qualitative researchers pursue an in-depth understanding of social events. Considering the researcher's subjective engagement in the qualitative research process (Lincoln & Guba 1985:224; Morse 2015:1213), using terminology which measure quantitative design, would not be effective (Brink et al 2012: 126-127; Cope 2014:89; Stommel & Wills 2004:440). Lincoln and Guba (1985:290-294) suggest a more naturalistic way to confirm the trustworthiness of a qualitative research design (Brink et al 2012:126-128; Morse 2015:1212). Their principles, discussed below, were used in the thesis.

3.4.1.1 Credibility

How can the researcher establish confidence that the research findings and the contexts in which they are presented are truthful? The answer to this question addresses the issue of internal validity and in qualitative terms is referred to as truth value. The naturalist (and critical realist) believes that there are multiple truths and accepts the responsibility to represent those truths as credibly as possible. Credibility can be established by using a study methodology which assists the researcher to conclude and construct a truthful narrative of the participants' reported reality. The researcher can also have the research findings approved by the participants (Cope 2014:89; Lincoln & Guba 1985:290, 295-296). For the historical researcher, the last mentioned was not possible because the historical participants are only represented by text (literature). As suggested by Lincoln and Guba (1985:301), as well as Polit and Beck (2014:325-326), credibility in the thesis was established by the research methodology and the researcher's prolonged and in-depth engagement with the research sample, namely literature that explains the history of professional nursing organisations in South Africa. Furthermore, the researcher provides credible evidence by means of multiple references. Multiple references illustrate corroboration (Fitzpatrick's 2007:384).

3.4.1.2 Dependability

Qualitative research is emergent in design (Lincoln & Guba 1985:317), which implies that the research process is not rigorously controlled, but rather that the researcher's search for the (historical) truth is guided by that (empirical event) about which reflective understanding has already been reached. The qualitative researcher follows the trail that gradually reveals itself in the data and so obtains knowledge of reality (note Chapter 2, Figure 2.2). Considering this basic research and the study's philosophical principles, the choice of research design must contribute to the dependability of the research. Her repeating of the historical inquiry cycle until crystallisation (invulnerable insights in critical realism) was reached enhanced the dependability of the researcher's findings. Only thereafter were final conclusions (judgements) made.

Qualitative researchers state that questions about dependability are about matters of consistency. Dependability (reliability) in historical research is enhanced if the researcher is familiar with the language, culture and customs of the period being studied (Barroso

2010:114; Cope 2014:89-90; Fitzpatrick 2007:383). The researcher's 25-year involvement as a South African registered nurse assisted her in reading documents written in Afrikaans and English. During the historical period being studied in this thesis (1914 to 2014), these were the two languages mostly used for official communication. Being trained in South Africa's multicultural health care system fostered a thorough understanding of the origin and nuances of South African nursing culture and encouraged the development of cultural sensitivity.

3.4.1.3 Confirmability

This criterion concerns itself with the position of the researcher in the study. One must consider how much the research conclusions are based on the (historical) data itself and how much can be attributed to the biases and/or influence of the researcher (Cope 2014:89). The qualitative researcher uses the term neutrality (instead of objectivity) and declares that the nature and characteristics of the data are more important than the position of the researcher (Lincoln & Guba 1985:290, 292-293, 299-300). As suggested by Lincoln and Guba (1985:281), the researcher demonstrated neutrality in this study by keeping a personal diary to record her reflections and introspective analysis of potential biases and undue influences. The researcher's prolonged engagement with historical inquiry as well as ongoing academic debates with the supervisor during the research process further ensured neutrality.

From the discussion, it is evident that qualitative researchers apply rigour (albeit non-linear) to their research. The acceptance of multiple truth realities, the uniqueness of the research phenomena and the subjective position of the researcher in the research process make generalisation of the findings impossible.

3.4.1.4 Transferability

In qualitative research it can be asked how applicable the research findings will be in other settings or contexts (Cope 2014:89) – their transferability. Transferability is not always possible, as the qualitative researcher might choose to study a group (such as South African nursing organisations) to discover how that group differs from other similar groups. The research findings might therefore be very specific to the context in which they occurred and very specific to group that experienced the events (this principle

complements critical realism's stance that causative mechanisms exert influence within a very specific set of circumstances). Finally, the qualitative researcher accepts that historical influences are unique and that the nature of such events does not facilitate comparison with other historical events (Brink et al 2012:127; Lincoln & Guba 1985:290-292, 296-298). The researcher did not prioritise transferability, as she considers her research findings as unique to the South African nursing environment. Rather, as suggested by Lincoln and Guba (1985:316) the research provides thick descriptions (of historical events) and leaves it to the reader to decide on the transferability of the findings. The thick descriptions are created by using a wide, information-rich database, which necessitates purposive sampling and considerations about sample size (Morse 2015:1214).

Although the research findings might not be transferrable, the researcher's use of critical realism to inform the historical inquiry methodology and her improved understanding of the historical inquiry process are. Critical realism's philosophical principles could assist other nursing historians to identify hidden causative mechanisms (note Chapter 2, Figure 2.1) in their areas of historical interest. The adapted historical inquiry process (note Chapter 3, Figure 3.2) illustrates to other nursing historians how a formal research project (such as a dissertation or thesis) must end within a set time. Yet, the end of the research project does not imply that no further historical research will be conducted. Rather, the conclusions and recommendations of the research project (thesis) stimulate further historical inquiry. The rich, thick descriptions of the historical narrative also have the potential to stimulate the reader's interest in a history topic other than the main topic under investigation. To illustrate: this thesis's main topic is the professional nursing organisations of South Africa, but mention is made of the interaction between the professional nursing organisations and SANC. Research into the relationship between the professional organisations (e.g. DENOSA) and professional nursing's governing body (SANC) might reveal previously unrecognised causative mechanisms that historically influenced the nursing profession.

3.4.1.5 Authenticity

Authenticity refers to the accuracy with which the researcher faithfully presents those feelings and emotions associated with the participants' experiences (Cope 2014:89). In the thesis the feelings of those who were participants in historical events became known

through their own writing (e.g. letters and diaries) and that of others (e.g. letters or reports). The research narrative uses quotes and the reader's interpretation of those quotes to convey feelings and emotions. However, before attributing specific feelings or attitudes to the historical participants (who are not here to confirm such claims made by the researcher), the authenticity of the historical documents from which such deductions were made becomes important. The use of documents and other forms of literature required the researcher to consider the authenticity (external criticism) and reliability (internal criticism) of the primary and secondary sources. This was done by means of a checklist against which she guided the inclusion of data obtained from historical documents (note Annexure B)

External criticism concerns itself with the genuineness of the document; for example its age, the type of paper that was used and the authenticity of the handwriting (Barroso 2010:114; Francis 2013:60; Sweeney 2005:69-70). External criticism was enhanced by the researcher's relying on primary sources in nursing archives that contain formal SANA Board reports, correspondence and some handwritten notes and letters. The genuineness of the archival minutes of meeting and letters was evident in their typewritten format, the coats of arms on documents and the signatures and/or names that correspond with nurse leaders who occupied leadership positions in that era. Official date stamps on documents also provide information about the era during which the document was in use. The genuineness of the documents in the private collection was verified by the owner of the collection, who herself participated in the post-1994 transformation of nursing organisations in South Africa.

Internal criticism asks if the document is trustworthy, and to establish trustworthiness the researcher considered matters pertaining to positive and negative criticism. Positive criticism required that terminology used in historical documents be understood within its correct, historical meaning and context, while negative criticism demanded that the researcher clearly distinguish between primary and secondary sources (Barroso 2010:114; Francis 2013:60; Sweeney 2005:69-70). The researcher's 25-year long involvement in the South African nursing profession facilitated the reading of the documents for historical context and meaning. Her fluency in Afrikaans assisted in the analysis of apartheid-era documents which were written in that language. To establish the trustworthiness of historical documents' content the researcher followed the guidelines of Barroso (2010:114) and Sweeney (2005:71) and differentiated between

historical fact, probability and possibility. The historical narrative in chapters 4 to 8 is factual, as evident by the richness in primary source references. Statements of probability and possibility (not confirmed by two primary sources) are indicated as such.

3.4.1.6 Primary sources: Reference to archive material

The researcher's dependence on primary sources in the data collection and analysis phases of the historical inquiry necessitated literature searches in more than one South African archive. Archives such as those of DENOSA, the University of the Witwatersrand and the University of the Free State have valuable documents that shed light on the history of South African nursing (and other) organisations. However, the use of primary sources from these different archives became problematic because the researcher could not use the exact same reference style for every historical source. The problem occurred because each archive has a unique classification system and therefore the information available for use in the list of references differs. To strengthen the truthfulness of the research findings and to ensure that other researchers could also find the archival material used in the research narrative, the reference guidelines of Burger (1992:111-113) were applied.

3.4.1.6.1 Unpublished archival sources

Unpublished archival sources were organised by referring to the name of the archive first. Furthermore, documents from the same archive were organised in chronological order. Burger (1992:112) suggests that each document's date must be written at the end of the reference because the date is often part of the historical document's title. For the sake of consistency in reference style, the researcher stated the date at the beginning of each reference; irrespective of whether the date was part of the document title or not.

3.4.1.6.2 Sources from a private collection

Referencing historical documents in a private collection posed a unique problem, as most reference guides are silent about the correct reference technique to use. The researcher recorded these documents on the list of references by using the author, the corporate author or (in the absence of a clear author) the title of the document. At the end of each entry, reference is then made to the owner and whereabouts of the private collection.

Sub-section 3.4.1 of the chapter explains the methods that the researcher implemented to establish trustworthiness in the research. Table 3.2. summarises the discussion and illustrates how the principles of trustworthiness were applied in the research:

Table 3.2 Trustworthiness

Principle	Criteria	Applied in research
Credibility	Researcher expertise	<ul style="list-style-type: none"> • Research methodology was also used in master's degree studies • This chapter illustrates growing understanding of methodology
	Prolonged engagement with research	<ul style="list-style-type: none"> • Previous historical research (Master's degree) • Four years researching the topic and writing the narrative
	Reflection	<ul style="list-style-type: none"> • Acknowledged the existence of multiple truths as guided by critical realism • Used the cyclical nature of the methodology to reflect on findings • Methodology and philosophical principles guided the writing of a truthful narrative • As new data emerged, reflected on the correctness of the already written narrative • Reflective diary kept
	Bracketing	<ul style="list-style-type: none"> • Used philosophical principles to place structures (e.g. culture) within a social context • Retrodiction first • Then retrodiction
Dependability	Research design	<ul style="list-style-type: none"> • Historical inquiry's cyclical nature encourages reflective understanding • Gathered data until crystallisation occurred
	Philosophical principles	<ul style="list-style-type: none"> • Thick descriptions led to insight • Obtained invulnerable insights from vulnerable insights • Only thereafter made judgements
	Researcher expertise	<ul style="list-style-type: none"> • Researcher familiar with topic of interest: prolonged (25 years) engagement in South African nursing
Confirmability	Research data	<ul style="list-style-type: none"> • The nature of the data is more important than the researcher's position in the research process • Allowed the data to speak; e.g. used quotes

Principle	Criteria	Applied in research
	Reflection	<ul style="list-style-type: none"> • Cyclical nature of methodology • Philosophical principles • Reflective diary
	Referencing	<ul style="list-style-type: none"> • Accurate referencing of primary archival sources
Transferability	Purposive selection of data sources	<ul style="list-style-type: none"> • Selected informative primary and secondary sources • Selected context-sensitive primary and secondary sources
	Thick descriptions	<ul style="list-style-type: none"> • Of historical events within a social context • Considered historical uniqueness
Authenticity	Feelings and emotions of historical figures	<ul style="list-style-type: none"> • Use of quotes • Checked authenticity of historical documents
	External criticism	<ul style="list-style-type: none"> • Checked if the historical document was real
	Internal criticism	<ul style="list-style-type: none"> • Identified primary sources • Terminology understood in historical context • Decide: historical fact, probability or possibility

(Cope 2014:89; Lincoln & Guba 1985:300)

3.5 ETHICAL CONSIDERATIONS

Ethical clearance for the research was obtained from the University of South Africa's Department of Health Studies (note Annexure A). The codes of ethics that guided the research are those published by the American Association for the History of Nursing (AAHN) (Lewenson & Hermann 2008:168-172) and the ethical (research) standards for nurses published by DENOSA (Brink et al 2012:48-51). Table 3.3 explains how the ethical codes were applied in the research: the ethical standard is stated in the first column while the application thereof is explained in the second column.

Table 3.3 Ethical standards applied in the research

Ethical standard	Applied in research
Research was conducted in accordance with the ethical principles of justice and beneficence	<ul style="list-style-type: none"> Careful consideration was given to the inclusion/exclusion of historical information: the historical truth was revealed without causing harm to participants' reputation or legacy.
Historical participants' recorded words (in documents) are represented with consideration of the participant's privacy, worth and dignity	<ul style="list-style-type: none"> The researcher reflected about what historical information to include, why it should be included and how it should be recorded in the narrative No private or personal details were included
The relevant historical research methodology was applied	<ul style="list-style-type: none"> Historical inquiry: data collection, data analysis, reflection and writing the narrative continued for four years Chapter 1 defines and differentiates between primary and secondary sources
The research purpose, objectives, methods of data collection and the benefit(s) to society are transparent	<ul style="list-style-type: none"> Chapters 1-3 provide detail about the research purpose, objectives and philosophical underpinnings that guided the research
Research findings were communicated honestly. Misrepresentation of historical events is regarded as academic dishonesty	<ul style="list-style-type: none"> Rich, thick descriptions of historical events and source references ensure transparency and honesty Bracketing was applied by means of a reflective research diary
Throughout the research process the researcher demonstrated integrity	<ul style="list-style-type: none"> Ethical clearance was obtained before commencing with the research Consent was obtained from archivists before accessing archival documents Archivists' requests and rules about the handling of historical documents were respected. No historical records were altered, removed or destroyed A self-evaluation check list was completed and signed at the end of the study (Annexure C)
The effect of biases on recorded history was recognised and managed	<ul style="list-style-type: none"> The influence of South Africa's socio-political history on nursing's professional organisations was acknowledged and discussed in the narrative Academic debates with the research supervisor prevented presentism and ensured neutrality A section of the research was presented at a research symposium for discussion

Ethical standard	Applied in research
The research is meaningful and contributes to nursing's body of knowledge	<ul style="list-style-type: none"> • The 100-year history of South African nursing organisations and its influence on the development of the profession has not yet been recorded; nor analysed
Within the confinement of available resources, the historical truth is represented	<ul style="list-style-type: none"> • Critical realism guided the historical inquiry to reveal the historical truth • Data collection and analysis continued until crystallisation occurred • A detailed resource list ensures transparency
History is represented in a responsible manner	<ul style="list-style-type: none"> • Consideration was given to historical terminology that might be considered offensive in modern day South Africa • Such terminology was limited and only used in unique quotes
The work of others is valued and acknowledged. Reasonable requests from other historians to have access to documents were honoured	<ul style="list-style-type: none"> • Quotes and references acknowledge the work of other academics • A comprehensive reference list enables fellow historians to access historical documents
Historical records were valued, not tainted or destroyed	<ul style="list-style-type: none"> • Archive material was handled with care. • Historical documents were photographed, thus limiting the use of writing material that might cause damage
Recognition that historical research creates a golden thread between the present, the past and the future	<ul style="list-style-type: none"> • The researcher identifies the hidden factors that influenced the development of the nursing profession in the period 1914 to 2014 • Based on the research findings, recommendations were made for the future

3.6 SUMMARY

Chapter 3 has explained the research methodology applied in the thesis. The researcher illustrated how her understanding of historical inquiry changed over time and how the philosophical underpinning of the study informed the research methodology.

The next chapter is the first of five chapters that represent the data collection and analysis phases of the research. It provides rich, thick descriptions about the circumstances and historical events that necessitated and enabled the establishment of the first professional nursing organisations in South Africa.

CHAPTER 4

ESTABLISHMENT OF THE FIRST PROFESSIONAL NURSING ORGANISATIONS

4.1 INTRODUCTION

To illustrate the influence that nursing organisations had on the development of professional nursing in South Africa, the researcher had to understand the society in which these organisations functioned. Before 31 May 1910, South Africa was a British colony (Spies 1993:45-47) and so the British influence (Searle 2001:9) on South African society must be considered. Victorian notions of family structure, where men were in a position of dominance and women were expected to be subservient (Esterhuizen 2012:43-44), had a significant impact on the health-care system's hierarchy, the doctor-nurse relationship and consequently, the professional status of nurses.

This chapter illustrates how the changing role of women in society and international socio-political changes influenced South African society and its nursing community. There was an international drive to establish nursing organisations, to create a professional nursing image and to obtain professional status for nurses. The narrative describes the factors that hampered the establishment of a South African nursing association in the late 19th and early 20th century. Once established, professional nursing organisations such as SATNA played an important role in creating South African nurses' professional image. The chapter concludes with a summary of the vulnerable insights (informed by critical realism) obtained from the historical data discussed.

4.2 SOCIO-ECONOMIC AND POLITICAL CHANGE

Before the outbreak of the First World War (WWI), British society was adjusting to the socio-economic and political changes triggered by the Industrial Revolution. Issues such as the exploitation of workers, workers' rights and protection of the workers became important and culminated in the creation of labour legislation and a state welfare system. This new socio-economic climate facilitated the entry of women, traditionally not economically active, into the workplace. An article published in one of the earliest *South*

African Nursing Record editions states that women joined the workforce partly from necessity and partly as a matter of choice. According to the author, valuable women workers, such as nurses, emerged. He further believed that although a woman's first duty remained to her children, times had changed and a woman's "mental activities" should not be discouraged (Woman's place ... 1915:64). Although women became workers, their new socio-economic status did not include the political right to vote or even participate in political institutions. In the British dominion of South Africa, Afrikaner women were for example expected to abide by the modest, passive and domestic role portrayed by British ladies (Möller 2010:62; Soine 2010:54, 74; Spies 1993:47, 49; Van der Merwe 2011:77-78, 80).

Considering that nurses in the late 19th and early 20th century were predominantly female (Sweet 2007:566), it is reasonable to conclude that socio-economic and political changes affected the nursing profession. Kane and Thomas (2000:21-22) confirm that gender roles, educational status and the industrial revolution effected change in the health-care environment. The traditional class system placed educated men (doctors) in the decision-making roles, while working-class women (nurses) were expected to serve. Even Florence Nightingale's lady nurses, who were chosen based on their good character and virtue, were reminded always to show deference to the physician (Rispel & Schneider 1990:21-23). The first edition of the *South African Nursing Record* explains the nurse's status in relation to that of the doctor as follows: "For her medical man the one lesson a nurse has to learn is obedience – implicit and ungrudging obedience" (Nurse, The 1913:21).

Such socio-political inequality disadvantaged women in that they did not have the same access to education as their male counterparts (Soine 2010:74). Yet, the industrial revolution demanded a new breed of nurses: ones with scientific knowledge and skill. Nurse leaders would use political leverage (such as the issue of suffrage) and education as their tools to craft a scientifically orientated professional image for nurses. Although suffrage for women was a popular cause, nurse leaders at first were hesitant to formally embrace the idea, as they feared antagonising their powerful male supporters. Thus, when Levinia Lloyd Dock proposed that the ICN adopt a resolution to support women's suffrage in 1909, it failed. It was only after a lengthy campaign, during which women's suffrage was tied in with the exploitation of nurses as workers, that the re-introduced resolution was accepted in 1912 (Soine 2010:63-64). Years later, Miss Borchards,

Chairperson of SANA, would refer to Levinia Dock and state that she worked “for the betterment of conditions for nurses and women generally” (Eleventh Quadrennial Congress 1958:30).

By that time, British, European and American nurse leaders realised that they had to address social, political and educational inequality if they wished to succeed in raising nursing to a professional status. Early 20th-century nurse leaders therefore strove to create the female professional image: a woman described by Soine (2010:65) as having “an ideological mixture of equal rights feminism, socioeconomic and racial superiority, and commitment to educational advancement”. Support for women’s rights to citizenship and suffrage would provide female nurse leaders access to male-dominated political power structures. This in turn would elevate nursing from being something all women could do to something that only trained women could do (Helmstadter 2007:155; Searle 1972:160, 162; Soine 2010:61-74). The difference between the status of a trained nurse and a domestic worker had to become evident in the nurses’ use of scientific medical technology and their salaries (Searle 1987a:109).

Not all nurses accepted the female professional concept with its focus on the nurse as an elite, educated worker. Since the days of Florence Nightingale and the religious sisterhoods, nursing was viewed as a vocation: a calling to take care of those in need, with little consideration of remuneration (Loots & Vermaak 1975:35; Soine 2010:65). The moral character of a nurse was considered more important than her education (Berghs, Dierckx de Casterlé & Gastmans 2006:118). This philosophical divergence was one of the contributory factors to the very religious Florence Nightingale’s decision not to support Mrs Ethel Bedford-Fenwick in her quest to obtain state registration for British nurses (Freeman 2007:168; Helmstadter 2007:155).

4.3 STATE REGISTRATION AND/OR PROFESSIONAL ASSOCIATION

To legitimise claims of being a profession, it was initially important to establish the female professional nurse image. Early 20th-century nurse leaders thereafter focused their efforts on establishing professional organisations and obtaining statutory recognition for nurses (Helmstadter 2007:157; Searle 1972:160).

4.3.1 British nurses: professional association, but no registration

The British Nurses' Association (BNA), established on 10 December 1887 by Mrs Ethel Bedford Fenwick and a group of matrons, was the first of its kind in the world. It quickly gained support, so that a year later, in October 1888, it had 1 146 members and two requests (from New South Wales and from New Zealand) to form chapters. By 1891, the BNA had approximately 50 000 members (Helmstadter 2007:156-7; Searle 1987a:137-138). Due to the involvement and support of prominent British male doctors, the Association's influence extended to the British colonies – one of which was the Cape Colony. Sister Henrietta Stockdale, a good friend of Mrs Bedford Fenwick, and her Kimberley nurses supported the BNA (Marks 1994:28; Searle 1975:3). In the late 1880s, Kimberley hospital had 40 nurses, the majority of whom were members (Loots & Vermaak 1975:99). In 1893 the BNA received the royal charter, which implied formal state recognition. Hence, the name changed to the Royal British Nurses' Association (RBNA) (Searle 1972:162; Soine 2010:79).

In April 1888, the newly established BNA had stated its organisational goals, which included the primary focus of obtaining state registration for nurses, thus legitimising nurses' claims of being a profession. Using the 1858 Medical Act (which established a self-governing British Medical Council) as a guideline, the BNA drafted a proposed state registration act for nurses. State registration would prevent inadequately trained nurses from practising (the BNA membership required the completion of a three-year training programme), create an exclusive status for the female professional nurse, entice gentlewomen to the profession and eliminate working-class nurses. (It was envisioned that future nursing students would have to pay for their training – something that working-class women could not afford.) State registration would therefore enhance the socio-economic status of BNA members (Helmstadter 2007:155, 157-158).

However, one of the reasons why Florence Nightingale opposed state registration for British nurses was her objection to the exclusion of working-class women. She valued clinical competence and expertise more than social status and prestige. In her opinion, nurses in the 1880s and 1890s were simply not sufficiently educated to claim professional status. In the words of Helmstadter (2007:158), Florence Nightingale believed that the proposed nursing registration act “would make nursing a legal profession, but a profession without legal rights”. It would give control of the profession to medical men and

leave nurses as second-class citizens in their own organisations (Helmstadter 2007:155, 158; Soine 2010:61-62). Mrs Ethel Bedford Fenwick came to the same conclusion. In an 1887 speech, she referred to the inclusion of physicians in the BNA's governing structure and argued that "the medical profession may always have a controlling voice in the management of the Association" (Soine 2010:62).

It was a conundrum: early 20th-century female nurse leaders needed male (medical) support to legitimise their claims of professionalism, but they also recognised that those supporters might very well hamper their striving for socio-political equality. Women's strategy of positioning themselves within the patriarchal system to obtain support for their endeavours would be evident until the 1940s (Marks 1994:3, 34, 40). In South Africa, this strategy was successful for even longer. Searle (1972:162-163) states that it was the involvement of prominent British doctors in the BNA that persuaded doctors in the Cape Colony to give Henrietta Stockdale's proposed state registration of nurses and midwives due consideration.

Internationally, the drive of nurses to obtain state registration in their respective countries resulted in several ICN member states such as Germany and the USA having nurses' registers by 1912. Mrs Bedford Fenwick's role as a founding member of the ICN, established on 1 July 1899, ensured that the BNA participated in international nurses' affairs from early on (Lynaugh & Brush 1999:4; Nursing Echoes 1934:33). Yet Britain still had no nurse register, because the nursing and medical professions could not come to an agreement on the issue of state registration. A few prominent hospital administrators, doctors and nurses (including Florence Nightingale) opposed the idea, citing economic and educational reasons. Some matrons feared that their hospital-based training programmes and certificates would not be recognised, while hospital administrators were concerned about added cost (Searle 1972:161; Soine 2010:52, 54). In 1912, in a *British Journal of Nursing* editorial (the first of the new year), Mrs Ethel Bedford Fenwick appealed for the state registration issue in Britain to be resolved as "others have outstripped us in attainment" (Soine 2010:57). She declared that British nurses were simply not on the same professional footing as their European and American contemporaries. Although British midwives obtained state registration in 1902, British nurses had to wait until the end of WWI in 1919 to obtain state registration (Searle 1972:162). In this, South African nurses took the lead.

4.3.2 South African nurses obtain state registration

On 17 July 1888, Sister Henrietta Stockdale and Dr Gerald Callender held a meeting with the nurses working in Kimberley and the district to discuss membership of the then BNA. They encouraged the nurses to become members, as it implied recognition of professional expertise. They also took it upon themselves to obtain more information about the membership registration process (Du Preez & Brannigan 1991:37; Searle 1972:164). Sister Henrietta herself joined the BNA on 7 March 1890, receiving member registration number 15 (King's Collections [Sa]).

Although it was not standard practice (only an ideal) in Britain at that time, Henrietta Stockdale and Dr MacKenzie extended their nurse training programme in Kimberley from two years to three years. This was done to ensure international (BNA) recognition for their work. Sister Henrietta explained in her 1889 report (the first) to the Kimberley hospital board that the nursing students received two years of training and worked for one year before being awarded a certificate of training, which entitled them to register with the BNA (Buss & Buss 1976:96; Loots & Vermaak 1975:107). Her report mentioned that four hospitals in South Africa were managed by matrons who were trained in Kimberley. She stated that these hospitals were managed “on the system in vogue here, and in connection with the British Nurses’ Association” (Loots & Vermaak 1975:107). This statement illustrates that the British system of training was adapted to suit South African needs; for example, smaller training schools were affiliated with larger ones, thereby giving students a greater range of experience and allowing smaller communities access to training (Searle 1985:5).

The high standard of training illustrated the BNA influence and would lead to South African nurses in the then Cape Colony being granted voluntary state registration with the passing of the Medical and Pharmacy Act (34 of 1891) (Marks 1994:28; Searle 1988:165, 168-169). Sister Henrietta Stockdale, supported by Sister Mary Agatha from Somerset hospital, was pivotal in the campaign for state recognition of trained South African nurses (Blignaut 1962:676; Loots & Vermaak 1975:110; Searle 1985:5, 164). For this achievement, Sister Henrietta was awarded the RBNA Gold Medal of Merit for Nurses in 1892 (Loots & Vermaak 1975:110).

Sister Henrietta valued state registration because she was concerned about nurses' poor economic and professional status. Additionally, the hope was that state registration for nurses in a British colony would sway the ongoing registration debate in Britain (Searle 1972:164, 167). Henrietta Stockdale's drive for state registration of South African nurses might also have had a more practical motivation. Her friend and supporter Lady Loch, wife of the British High Commissioner and Governor of the Cape (1889–1895), recollected that Sister Henrietta often received cryptic telegrams asking her for assistance and experienced nurses. However, such telegrams did not explain the type of illness involved, nor did she know what experience (e.g. surgical or medical) that nurses so requested should have. A register listing nurses' qualifications would have assisted her in sending the most appropriate nurses to manage the health needs of the community (Project Canterbury 1914).

4.3.3 A South African professional organisation: slow progress

At the beginning of the 20th century, South Africa's nursing force was small, and the nurses were predominantly of English and European descent. Few Afrikaner women and even fewer Black women trained as nurses. By 1899, there were approximately 3000 nurses in a region which stretched from modern-day Zimbabwe (Matabeleland) to Botswana (Bechuanaland) and across South Africa (Marks 1994:45, 63, 68; Searle 1985:6). The pace at which South African professional organisations developed was influenced by this small number of nurses in relation to such large geographical area. A hundred years ago, transport and unreliable means of communication hampered interaction between nurses working across such a large area (Alexander 1926:935). Both in the first and later editions of the *South African Nursing Record*, the editor considered the lack of formal communication as problematic (Editorial Notes 1913:7; Trained Nurses 1914a:420). Organising of conferences and meetings was a slow process. A map to illustrate late 19th-century Southern Africa is included below. Note the vastness of the semi-desert (Great Karoo) region, the town of Kimberley in the middle of the map and its distance (956 km) from the Cape Colony's parliament in Cape Town.

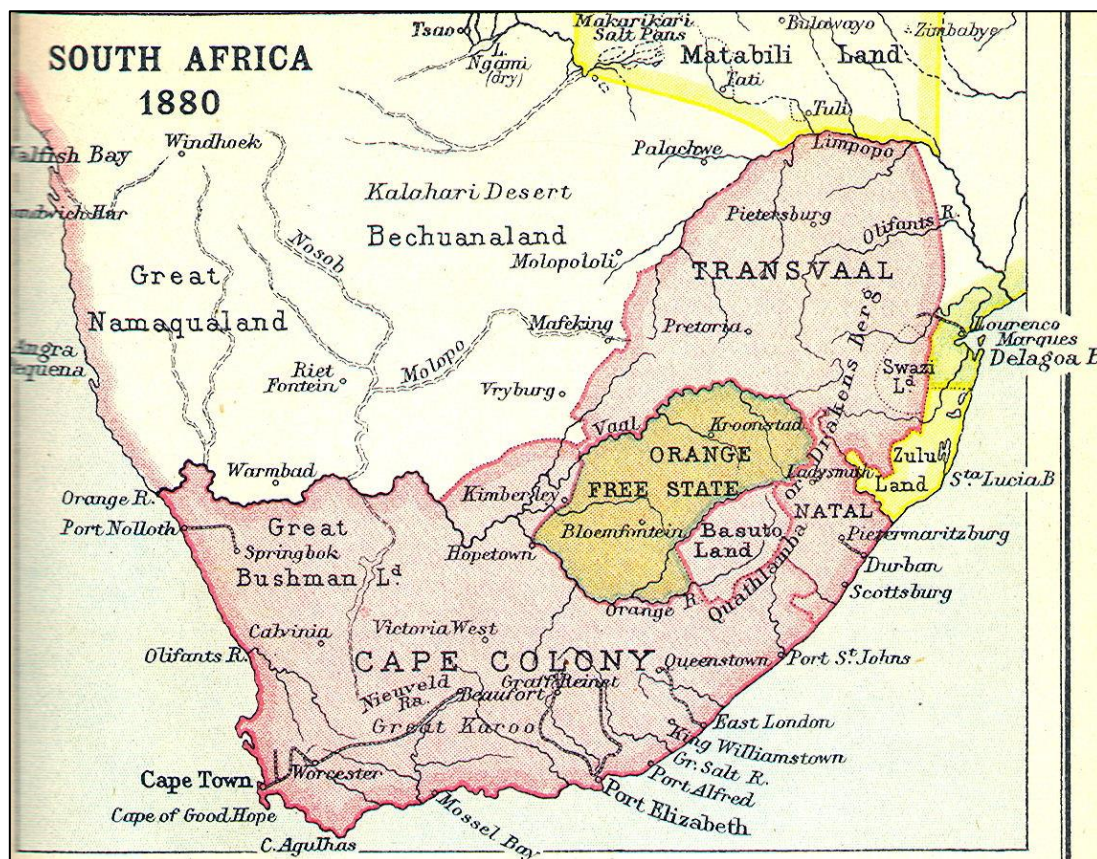


Figure 4.1 South Africa in 1880

(Südafrika Karte Geschichte [Sa])

Although Southern African nurses were the first in the world to obtain state registration, it was exactly this achievement and Henrietta Stockdale's dominant role as spokesperson for the small number of qualified nurses that delayed the establishment of a professional nursing association (Du Preez & Brannigan 1991:37; Searle 1972:238). The King's Collections ([Sa]) refer to her being "regarded as a saint by some and as a keen business woman politician by others." In Kimberley, she was in close communication with prominent medical and political men who assisted her in the nurses' drive for state registration. She visited Cape Town and had interviews with politicians such as the Chairman of the Select Committee on Medical Reform, Dr WG Atherstone, requesting him to support the inclusion of registered nurses and midwives in the then proposed medical bill (Buss & Buss 1976:97, 99; Marks 1994:113; Searle 1975:3). She wrote letters to prominent medical doctors and her Kimberley hospital report was presented to Parliament (Marks 1994:34; Searle 1972:146, 165). Her role as the spokesperson for nurses is confirmed in Charlotte Searle's 1984 Henrietta Stockdale memorial lecture. Searle refers to her as a "political" nurse who maintained that the development of the health-care system (and by implication nursing) "is the cornerstone of economic progress"

(Searle 1988:149). She further accredits Sister Henrietta with achievements that closely resemble the key characteristics of a professional association: creating a system of nursing education, establishing a philosophy of service, and instilling the principles of professional accountability (Searle 1985:4-5).

War creates circumstances and favours priorities that seldom echo those of peace time. The outbreak of the South African War (SA War) (1899–1902) contributed to the delay in establishing a South African nursing association. The *South African Medical Journal*, which had a section devoted to nursing matters, was discontinued during the war (Searle 1965:238), further limiting communication with nurses who were working in remote regions of the country. Spokesperson Henrietta Stockdale was caught up in the siege of Kimberley, with little or no communication with the outside world, striving to survive shell attacks and starvation. On 12 December 1899, she stated: “war is a fearful thing; the ruin and heartrending tragedies everywhere are dreadful indeed. Of course, our work is ruined” (Buss & Buss 1976:111).

The SA War also brought overseas nurses to Southern Africa, many of whom were members of the RBNA. They, along with the locally trained nurses (most of them also members of the RBNA) were content to remain under the banner of that professional organisation (Searle 1972:238-239). Sister Henrietta herself expressed concern about the absence of a South African nurses’ association, but ill-health prevented her from taking the lead in establishing such a professional organisation. She died in 1911, before an independent South African professional nurses’ association could be established. By 1914, Dr Thorton, the Medical Inspector of Hospitals and Charitable Institutions in the Cape Province, warned that nurses would need their own governing body because they were not represented on the Medical Councils (Buss & Buss 1976:120; Marks 1994:42-43, 118-119; Report Medical Inspector 1914:315).

4.3.4 Early efforts to establish a nursing association in South Africa

The Medical and Pharmacy Act (34 of 1891) that made provision for *voluntary* state registration of nurses was applicable to those working in the then Cape Colony. State registration for nurses was implemented only later in British-controlled Natal (1899) and in the then Boer Republics of the Orange Free State (1893) and the Transvaal (1904) (Radloff 1970a:6; Searle & Pera 1993:11-12). This implied that there was no central

register on which to record the names of trained nurses in Southern Africa. It also implied that not all hospital-based nursing training was in accordance with the 1891 Medical and Pharmacy Act requirements. In fact, many small hospitals were eager to have their training formally recognised, but in the words of Miss BG Alexander (SATNA General Secretary 1915-1932) these “fail to realize that their demand, if acceded to, tends to keep the professional standard low” (Alexander 1926:935). Lesser trained and non-examined nurses could continue to practise their craft (Searle 1972:168-169), but nurses’ professional status found itself on the shaky legs of a new-born foal: daily reality (*de facto*) did not reflect what was required in law (*de jure*) (Radloff 1970a:6).

The statutory (state) recognition given to Southern African nurses was their first step to being recognised as a profession. However, the fact that it was done voluntarily, was managed by four different Medical Councils (Cape Colony, Natal, Orange Free State and Transvaal), lacked a formal professional association and experienced the influx of overseas nurses contributed to the first episode of professional discord.

After the SA War (1899–1902), many of the nurses from Britain and its colonies who had come to Southern Africa to participate in the war effort remained in the country. This created a nursing corps that was diverse in culture and in training, consisting of those from overseas and a few locally trained, religious and secular nurses (Marks 1994:45; Mellish 1985:44). A degree of snobbery arose: British nurses did not consider locally trained nurses as being of the same social and educational standard as themselves. Trained, upper-class British nurses were given preference in public hospital appointments (Report Medical Inspector 1914:314). Dr John Tremble (himself British) remarked that “it was the rarest possible thing to find a South African trained nurse in any senior administrative position” (Marks 1994:63; Searle 1965:241). Marks (1994:46-47) declared that these upper-class British women were sent to “anglicise the conquered Boer republics”, and called Henrietta Stockdale “the linchpin of the scheme in South Africa.” This dominance ensured that British nurses exerted an enormous influence on the developing Southern African nursing profession’s principles and ethical standards.

Sister Henrietta’s role as spokesperson of a core group gradually changed as the number of nurses in Southern Africa increased and became more diverse. The overseas nurses were not acquainted with her informal, professional leadership role as the voice of local nurses (Searle 1965:238). In 1905, while Sr Henrietta and her protégées, Sister Mary

Hirst Watkins and Miss JC Child, were taking steps to establish formal RBNA branches in Southern Africa, another group of trained nurses established a South African Nursing Association. The new association, established as a branch of the RBNA under the leadership of Miss Hannah, received approval from the RBNA President, Her Royal Highness (HRH) Princess Christian. Miss Hannah's nursing association planned to involve itself with the professional development of nurses (by organising lectures and discussions) as well as their socio-economic welfare (by creating a pension fund, a sick fund and convalescent homes for nurses) (Searle 1965:239).

In Britain, the RBNA kept a register of trained nurses and provided them with membership certificates. It was accepted practice that a RBNA certificate ensured its holder automatic entry on any nursing register held in British colonies. RBNA members such as Miss Hannah therefore expected automatic entry to the South African nursing registers, without submitting to any local Medical Council examination (Marks 1994:117; Searle 1972:239). Southern Africa however, had a fundamental statutory control system in place which managed the emerging nursing profession, one which nurse leader Henrietta Stockdale valued dearly (Searle 1965:239).

After being denied certification as a nurse by the Colonial Cape Medical Council and the Natal Medical Council, Miss Hannah (and her supporters) maintained that being a member of the RBNA automatically allowed her entry to South African nurse registers (Searle 1965:239). Her new nurses' association planned to keep its own trained nurses' register (as was done in Britain) and to provide members with certification. The four South African Medical Councils were requested to recognise these certificates. After deliberation, the Medical Councils rejected the notion that Miss Hannah's association could keep a nurse register separate from that required by legislation and managed by them. Professional status was awarded by the Medical Councils and by means of legislation, such as the 1891 Cape Medicine and Pharmacy Act (Searle 1972:169). Sister Henrietta also did not support Miss Hannah's association's objectives. Her long-term vision was that the state (not a nursing association) should accept responsibility for the statutory management of the nursing profession and its training (Du Preez & Brannigan 1991:37; Harrison 1982:4; Searle 1972:239-240).

Miss Hannah and her supporters failed to recognise that legislation awarded Southern African nurses a unique statutory position. The assertion that her professional association

had the right to certify nurses (and by implication manage the nursing profession) challenged that statutory position and alienated the association from those with statutory control. Without the support of the four provincial Medical Councils and the acknowledged nurse leaders, Miss Hannah's association was doomed to failure. The organisation could not acquire professional exclusivity and legal status for its members.

4.3.5 The professional nurse image

A comparison between Miss Hannah and Sister Mary Hirst Watkins illustrates that over time a professional nursing organisation influences the educational standard of the profession. The comparison further illustrates the fact that a profession, if organised, assures its approved members exclusivity and status. Professional exclusivity in early 20th-century South African nursing was semi-formal in nature because the recognised nurse leaders had not yet established a formal nursing organisation (note the reasons for this in sub-section 4.3.3 of this chapter).

Searle (1965:240) quotes the Cape Colonial Medical Council's statement on 27 October 1905 that they could not accept the certificates of Miss Hannah's South African Nursing Association (a recognised branch of the RBNA) because "the Council has not recognised the certificate of the Royal British Nurses' Association for registration for the last twelve years", that is since 1893 (as calculated by the researcher), which was also the year in which the BNA received the royal charter (Soine 2010:79). Yet, just a year earlier, on 6 September 1892, Sister Mary Hirst Watkins had become one of the first registered nurses in the world when the Colonial Medical Council accepted her BNA certificate and granted her entry on the Register for Trained Nurses. After completing her three-year training (two years of training and a third as a staff nurse) in London and obtaining BNA membership, she was brought to Kimberley by her brother, Dr Arnold Hirst Watkins, who was known to be very active in medical politics. She became one of Henrietta Stockdale's closest friends (Buss & Buss 1976:95; Searle 1987a:104). Today they are buried side by side at the foot of the Henrietta Stockdale statue at the St Cyprian's Cathedral in Kimberley.

To explain why Sister Mary Hirst Watkins was accepted to the Cape Colonial Register in 1892 and Miss Hannah refused in 1905, factors related to education and social class must be considered. Sister Mary Hirst Watkins was a British lady who complied with the BNA's professional nurse training requirements. She was well-educated and moved in

influential social circles (her brother being a politically active doctor and her best friend a prominent nurse leader). Educationally and socially privileged, she was ideally positioned to (in 1892) become one of the first state registered nurses in the world, shortly after the 1891 legislation in the Cape Colony enabled the creation of a register for trained nurses.

The BNA attempted to establish a professional nurse image by drawing educated women to nursing. This is evident in a *South African Medical Record* article published on 10 February 1906. The article mentioned that the *British Journal of Nursing* (the voice of the BNA) criticised the Transvaal Medical Council for registering British nurses on the sole grounds that they had a BNA certificate. In those early days, not all BNA members complied with the envisioned three-year training period and thus not all could be considered well trained. The *Medical Record's* editor then confirmed that British (and other foreign nurses) were required to write the same examination as those trained locally, because there was no system of state registration (and thus educational standard) in Britain (Passim 1906:29-30). Miss Hannah, an uncertificated nurse by Southern African standards (Buss & Buss 1976:95; Searle 1965:239), would therefore be required to write the colonial examination even though she had a BNA certificate. Sister Mary Hirst Watkins's acceptance for state registration in 1892 was in part because she had complied with the BNA's envisioned three-year training requirement.



Figure 4.2 Henrietta Stockdale statue and grave, Kimberley, South Africa

4.4 LADY NURSES IN A CHANGING SOCIETY

Victorian ladies and their daughters were expected to be involved in charity work, such work being their only reward. They had a duty to care (Berghs et al 2006:120; Damant 2010:590). It was also believed that caring and healing in the name of religion was more effective than without. The missionary doctors and nurses' priority were therefore first to spread the Christian faith, and secondly to heal (Gelfand 1984:17-19). Lady Loch recollected that Sister Henrietta Stockdale expected her trained nurses to be energetic in their work. More importantly, she expected them to work with honesty and integrity stemming from a strong religious conviction (Project Canterbury 1914). In this way, the religious sisterhoods bestowed on nursing practice the ethical principles of discipline and selfless service. These early groups of nurses also established the notion that patient care should be conducted under the leadership of a "lady" – the trained (British) nurses being from the higher social classes (Marks 1994:43).

The late 19th-century lady nurse held a leadership role within the hospital, yet such powers were dependent on the goodwill of the medical (male) doctors. Henrietta Stockdale, being aware of the patriarchal society in which she functioned and adhering to the professional etiquette taught by Florence Nightingale, carved out an independent (be it limited) role for herself. She did so by creating working relationships with the medical, political and religious leaders of the day (Berghs et al 2006:119; Marks 1994:114-115; Searle 1985:4). Dr Callender and Dr Hirst Watkins (brother of Sister Mary) assisted in the campaign for the 1891 state registration for nurses (Searle 1965:163). Cecil John Rhodes and Dr Leander Starr Jameson (synonymous with the Jameson Raid of 1895-1896) served on the Kimberley Hospital Board where Sister Henrietta was the first Sister-in-Charge. In her SA War diary, Sister Henrietta mentioned that Rhodes regularly provided the sisters with fruit and vegetables during the siege of Kimberley (Buss & Buss 1976:71, 87, 101, 113). Other South African nurse leaders would follow her example to network with the male medical leaders of the day. In 1934, the eminent Dr AB Xuma, practising in Doornfontein, Johannesburg, was invited to become an honorary member of the Bantu Trained Nurses' Association (BTNA). Dr Xuma became the President of the ANC in 1940 (South African History Online 2016). He attended the second annual BTNA meeting which was held on 9 December 1934. Also attending that meeting was Mr. JD Rheinallt Jones, the then Advisor to the South African Institute of Race Relations (SAIRR) (University of Witwatersrand 1934b).

Early 20th-century women's traditionally home-based role was transformed due to the influences of the SA War, industrialisation, urbanisation and the Great (economic) Depression. The result was a liberal socio-economic society in which men suddenly had to compete with women in the labour market (Marks 1994:120), while female workers strove to have their voices heard. The resultant tension was effectively illustrated in communication between SATNA and the Medical Council. The *South African Medical Record's* January 1918 leading article, titled "The Trained Nurses' Association and the Medical Councils" was published in reaction to SATNA's comments about the Medical Councils' management of Military Probationers and Coloured nurses. After a two-and-a-half-page rebuttal, the Medical Council concluded that although doctors were thankful for the assistance of trained nurses and had sympathy for their striving to become an independent profession, "it will be most regrettable if this leads to an ignoring of the essential fact that the nurse ought always to be a sub-ordinate assistant of the medical practitioner" (Trained Nurses 1918:3). Evidently women nurses were aware of (and straining against) the subservient role they were awarded and their dependence on the support and approval of the male doctors (Marks 1994:120; Third Annual Meeting ... 1918:151).

In the political arena, men reacted by emphasising the important caring role of women at home and in society (Van der Merwe 2011:83). Dr GP Mathew's Presidential address to the Eastern Province Branch of the British Medical Association in March 1920 illustrated this point. He commenced his speech by referring to "the woman's question" which was gaining momentum: "the gradual struggle to the surface of those who for long have been kept under." Dr Mathew lamented the fact that few women seem to appreciate their unique ability and role "in the propagation of the species". In the workplace, a woman could not be more than a man's equal, but in the home, she is superior and the "potential source from which a long line of historical stars may rise." The good doctor believed women should strive to work for the health of the nation, blaming the ills of society on those women who were too busy with "self and trivial pleasures" (Mathew 1920:109-111). From the 1920s onward, nationalist Afrikaner women's organisations such as the Suid-Afrikaanse Vrouefederasie (SAVF) confirmed the importance of women managing their homes and families. It was an early indication of what later in the 1950s would be referred to as *volksmoeders* (Marks 1994:68-69).

The view that women were professional persons and workers echoed Lavinia Dock's 1913 speech to the American Nurses' Association (ANA). On 26 June 1913, she called on nurses to consider issues not only of professionalism, but also of education and remuneration, as she felt that nurses as a workforce were being exploited (Soine 2010:51). The Industrial Revolution necessitated the creation of specialised labour: persons with training and certification. Training had to be provided by professional training schools, with certification managed by a professional organisation, thus establishing an elite group with its own expertise and ethics (Searle 1987a:123). Dr John Tremble, the man who played a key role in establishing SATNA, advocated that nurses should constantly adapt their practice to accommodate changes in societal thought and contexts. In response to the statement that nursing was not what it used to be, he replied: "Why should it be the same? Society is not what it used to be" (Searle 1975:14). In fact, he expected nurses to anticipate change – and act in a way that would establish professional and ethical standards of which future South African nurses would be proud (Traditions 1915:107-108). The best way of illustrating their professional status as trained nurses was by wearing a distinctive nurses' uniform (Uniform, The 1915:187).

For some, the notion that nurses had the right as workers to remuneration created ideological discord, because the religious sisterhoods' premise was one of charity. In Germany, for example, referring to nurses as workers would have diminished the social status of the deaconess nurses (Soine 2010:65). Searle reflected on the nature of nursing after the SA War (1899-1902) and concluded that the military-style discipline instilled in nurses hampered their economic progress for more than 50 years because of "their dedication, conscientious servitude, frugality and willingness to accept underpaid, under-equipped, understaffed and overworked situations" (Searle 1987a:112).

4.5 DEDUCED FROM THE DATA: VULNERABLE INSIGHTS

The colourful tapestry which represented early 20th-century nursing history was created by causative mechanisms such as specific socio-economic influences and the changing roles of women in society. Damant (2010:588-589) described British district nurses' training and working in the period 1910-1930:

“Such Queen’s Nurses spent their early years during the Boer War (1899-1902), their nursing career during the First World War and, had they survived to middle age, would have lived through the Second World War and witnessed the new focus on the changing role of women in society and the expansion of their rights.”

The Industrial Revolution enabled women to enter the workplace, while technological development and war necessitated trained, skilled nurses. The economic role of women in 19th and early 20th century society therefore changed, yet culturally they remained subservient. That meant that in the health-care environment, doctors (male) directed nurses (female) and nursing matters. Nurse leaders (such as Henrietta Stockdale in the Cape Colony) functioned within this socio-cultural system by aligning themselves with powerful male medical and political leaders and in so doing influenced the developing nursing profession’s educational standards and practice.

Early nurse leaders were concerned about the poor socio-economic position of nurses. The best way of changing that was to create a professional nurse image and have nursing declared a profession. Professional status generally implied exclusivity and skill, which ensured members of the profession of a higher income. For these reasons, the establishment of professional nursing organisations, state registration for nurses, the elimination of untrained nurses and instead attracting educated, upper-class women to nursing were of the utmost importance. The drive for professionalism started with the formation of an educated elite. In Southern Africa, Henrietta Stockdale and Dr MacKenzie adapted their nurse training programme to comply with RBNA requirements and so gained an international recognition for their nursing training and standards of practice. Sister Henrietta’s training programme and her close contact with influential doctors and politicians (male support) created favourable circumstances in which she and her supporters could campaign (successfully) for state registration. Trained Southern African nurses obtained state registration in 1891. It is evident that early nursing organisations such as the RBNA positively influenced the standard of nurse training (as far as Kimberley, South Africa) and the resultant professional status of their members. In later years, SATNA campaigned for the right to display the professional status of state-registered nurses by means of an exclusive nurses’ uniform.

Women’s entry into the workplace and the drive of nursing organisations to establish a female professional image created an awareness of the difference between charity and

remuneration. Women nurses were becoming professional, uniquely skilled workers who had the right to earn fair wages. Traditionally the privileged upper-class women in Western society had extended a charitable hand to those less fortunate. Charitable work was considered a Christian duty with no financial reward. In colonial Southern Africa, the presence and dominance of such upper-class women in nursing greatly influenced the profession's standards of practice and ethics. Discipline and noble selfless service were considered of the utmost importance. The struggle between nurses being remunerated as professional workers or being treated as charitable workers continued for many years.

Although ineffectively formulated, the 1891 Cape Medicine and Pharmacy Act was the first time that nurses anywhere in the world received statutory recognition as a profession. The act did not establish professional exclusivity, because it regulated only those trained nurses who *volunteered* to be registered while allowing the untrained and unregistered nurses to continue practising without fear of prosecution. As for the establishment of an independent and influential South African nursing association, statutory recognition, as well as the powerful presence that was Henrietta Stockdale, contributed to the delay in achieving that goal sooner. Other factors that also delayed the process were the communication challenges created by the vastness of the country and the outbreak of the SA War. Finally, most trained nurses in early 20th-century Southern Africa were British, and they were content to remain members of the RBNA.

Figure 4.3 provides a historical timeline that illustrates the significant events that occurred in South Africa, the world at large, and its influence on the development of South Africa's professional nursing organisations.

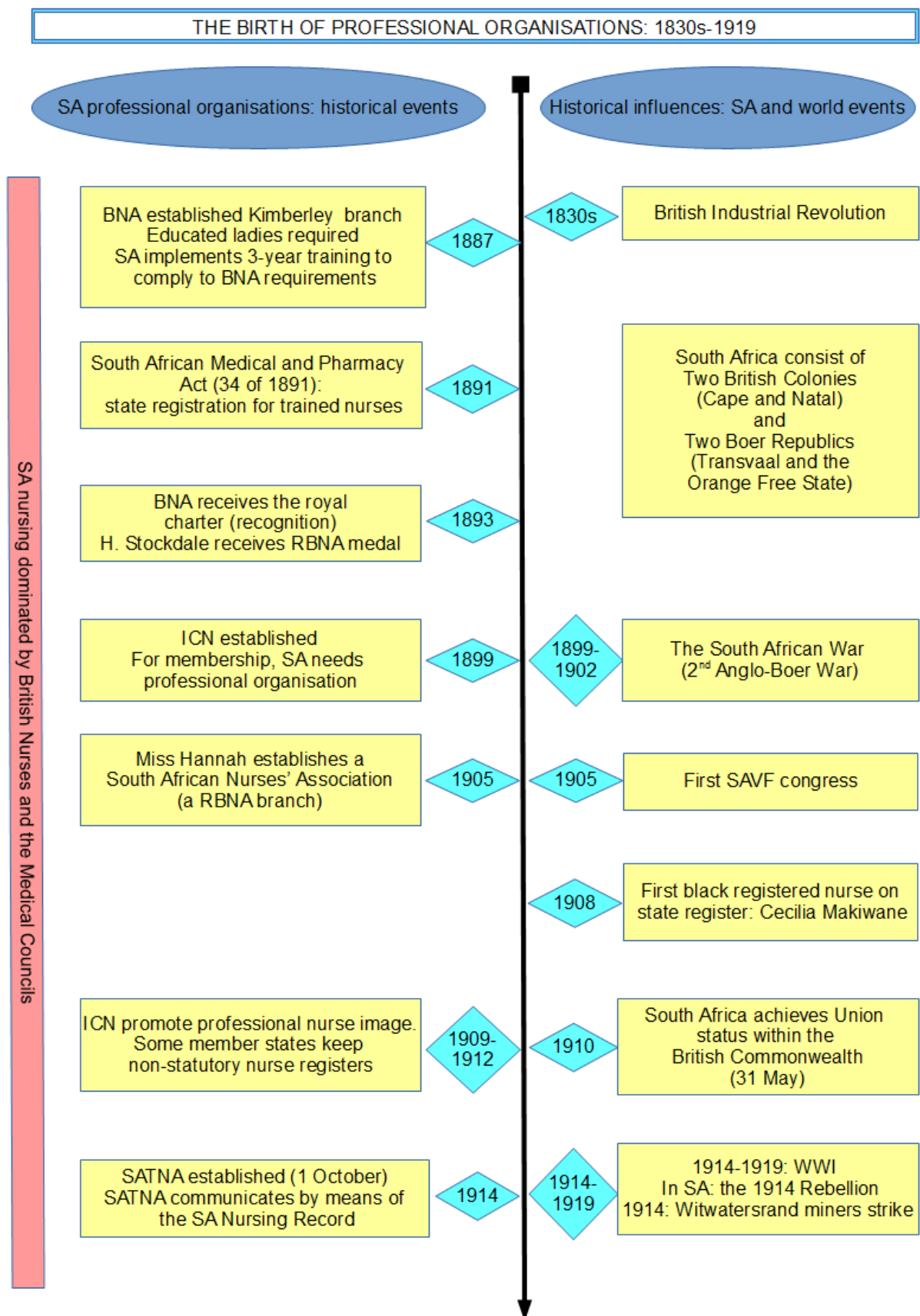


Figure 4.3 The development of professional nursing organisations in historical context

4.6 SUMMARY

In this chapter the causative mechanisms that contributed to the establishment of the first professional nursing organisations were identified. Political (e.g. WWI) and economic factors (e.g. the Industrial Revolution) changed early 20th century societies and enabled women (e.g. nurses) to become economically active. However, culturally women continued to occupy a subservient role. Socio-economic and socio-cultural factors therefore acted as causative mechanisms; motivating the drive to establish professional nursing organisations and a professional image. Chapter 5 of the thesis introduces the first influential South African nursing organisations, namely SATNA and BTNA.

CHAPTER 5

THE FIRST INFLUENTIAL SOUTH AFRICAN NURSING ORGANISATIONS

5.1 INTRODUCTION

Chapter 4 of the thesis illustrated how budding professionalism in the late 19th and early 20th century started to change the training standards for nurses and as a result altered the status and image of nursing. At that time, South African nurses did not have an independent nursing association as the (mostly English) trained nurses in the country preferred to remain members of the RBNA. Although nursing had obtained statutory recognition in 1891, the drive for an independent South African association was slowed; consequently South African nurses' professional affairs would be managed by the medical profession until the establishment of an independent SANC and SANA on 6 June 1944 (Searle 1982a:47).

In this chapter, the key role that the first two influential South African nursing organisations, namely SATNA and BTNA, played in the development of the nursing profession over a period of thirty years emerges from the data. The narrative describes how these nursing associations enabled South African nurses to participate in the decisions being taken about their professional practice and work conditions. Nurses through their professional organisations began to participate in decisions about their profession.

5.2 SOUTH AFRICAN TRAINED NURSES' ASSOCIATION 1914–1944

This section describes the causative factors that contributed to the establishment of SATNA: its aims, professional activities, successes and limitations. The discussion commences with a brief description of the historical events that dominated society at the time that SATNA was established. The value of providing such historical context is that hidden agents and structures that influenced SATNA decisions, and by extension the development of the nursing profession, can be recognised.

5.2.1 South Africa before the outbreak of World War I (1914–1919)

In the early 20th century, perceptions about race were influenced by what Welsh (2000:372) calls “social Darwinism”, meaning that those who were perceived as being of a lower social (racial) order had to be taken care of, in a type of guardianship. Southern Africa fell under British control after the SA War of 1899 to 1902, and social Darwinism in the region translated into White people overseeing the Black, Indian and Coloured populations (Welsh 2000:364-373, 415). Negotiations in 1910 to establish the Union of South Africa (a British dominion) therefore did not award these “non-European people” voting rights, nor were they directly represented in government. This key socio-political issue, however, had to take a backseat to an even more momentous historical event.

On 4 August 1914, Britain declared war on Germany. This meant that Britain and its dominions (South Africa being one) were actively involved in WWI. Britain requested the Union government to invade German-occupied South West Africa (modern-day Namibia). The request created political unrest in South Africa. The Union government leaders and the leaders of the then South African Native National Congress (later the ANC) pledged their loyalty to Britain (Spies 1993:96, 124), yet many Afrikaners still remembered the hardships suffered during the SA War and opposed the idea of supporting Britain in WWI. After some military forces left South Africa for Europe and while the Union government prepared to invade South West Africa, Afrikaner rebels staged the 1914 Rebellion. The Union government reacted swiftly and on 11 October 1914 declared martial law (Spies 1993:93-95, 106; Welsh 2000:279-380). The SATNA, established on 1 October 1914, was 10 days old. Welcoming the new British Governor-General, the King’s representative (Welsh 2000:399) and his wife (the future patroness of SATNA) to South Africa, the editor of the *South African Nursing Record* remarked that “he must be an actual leader in a country where there are not only two very opposite white races, but also a huge and restless native population” (Lady Burton 1914:14).

In South Africa, the political drama of the early 20th century spilled over into industrial unrest: in 1913 to 1914 there were several miners’ strikes and a railway workers’ strike (Spies 1993:83-85; Welsh 2000:382-383). Issues related to job security and the emergence of trade unionism led to these strikes, which illustrated an emerging awareness by South Africans about their rights as workers. In post-1910 South Africa, while trade unions were not illegal, they initially did not have statutory recognition. The

first bill for the registration of trade unions was only to be introduced in 1914 (Spies 1993:78-79; South Africa 1914:viii).

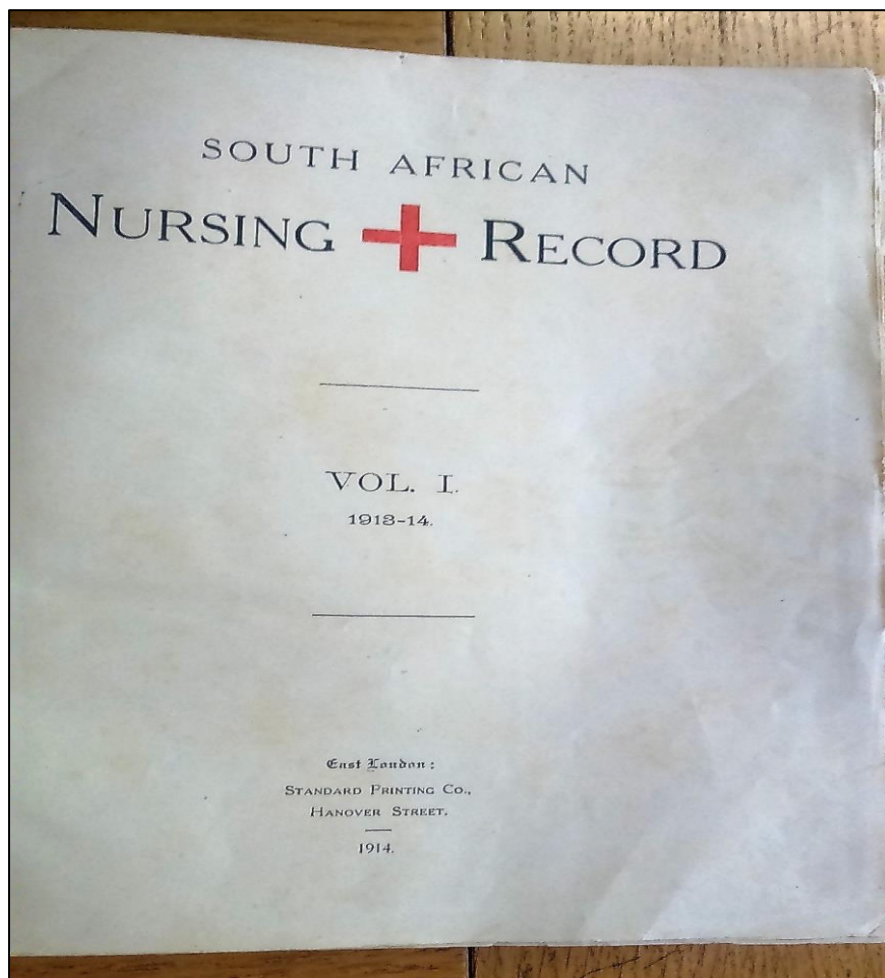
At the outbreak of WWI (1914), when large numbers of trained nurses left South Africa to participate in the war effort (Alexander 1926:936; Gelfand 1984:117; Present effect...1916:118), nursing was a low-paying profession, managed by the four provincial Medical Councils. Nurses had meagre training facilities and still no formal communication system (Report Medical Inspector ... 1914:315; Searle 1982a:13).

5.2.2 The establishment of the SATNA

Although all four South African provinces had had a form of state registration for nurses by 1904, as a collective they remained voiceless and had no independent professional status (Alexander 1926:936). This was effectively illustrated in a letter dated November 1906 and addressed to the editor of the *South African Medical Record*. The letter, written by Miss JC Wood, explained that nurses' work and their training were managed by the matrons, sisters and teaching staff in the hospital. Yet the Medical Councils, who were not involved in their training, managed the nurses' examination and state registration. The perceived lack of cooperation between nurse trainers and medical examiners was to the detriment of the nursing students. Miss Wood suggested that a committee be established with the purpose of allowing nurses to advise the Medical Councils on practical nursing examinations. She argued that such cooperation would make the nurse registration process more efficient. Miss Wood's appeal to allow nurses input into the examination and registration process was rejected by the *Medical Record's* editor, Dr W Darley-Harley, who "gravely doubt[ed] the practicability of such a committee" (Wood 1906:285).

In these trying circumstances, Miss JC Childs (Henrietta Stockdale's protégée) and British doctor John Tremble recognised the need to have a formal means of communication for nurses in southern Africa (Editorial Notes 1913:7; Mellish 1990:126; Trained Nurses' ... 1914a:419-420). With no funds, but with the goodwill of Dr Tremble and a local printer, Mr CJ Smith, the first edition of the *South African Nursing Record* was printed and sent to hospitals and nursing agencies in October 1913. The founders' long-term aim was mentioned in the first few editions of the journal: to establish an independent professional nurses' organisation which could represent nurses on the provincial Medical Councils when matters of nursing training, examination, registration and control were discussed

(Du Preez & Brannigan 1991:37; Marks 1994:118-120; Searle 1982a:14-17). The first edition of the *South African Nursing Record* described the professional character that SATNA was striving for. It contained editorial notes about the role of the nurse and the spirit of nursing, original contributions about “Operating theatre methods and their evolution”, notes about infant feeding, nursing training matters and a discussion about “sick room cookery” (*South African Nursing Record* 1913). It was also telling that the first sentence of the first article in the first edition is dedicated to the life and work of Florence Nightingale: “She lived her life striving after an Ideal” (Florence Nightingale 1913:5).



**Figure 5.1 Title page of the first edition of the *South African Nursing Record*:
October 1913**

(*South African Nursing Record* 1913)

SATNA officially came into existence on 1 October 1914. The new association adopted the *South African Nursing Record* as its official voice in print (Searle 1982a:17-18; Trained Nurses' ... 1914b:13; Trained Nurses' ... 1914c:36). Miss BG Alexander (1926:936) explained that SATNA started “with less than 100 members, a portion of whom were not

too enthusiastic or hopeful". The few members were spread across the two former British colonies (Cape and Natal) and the two former Boer Republics (Orange Free State and Transvaal) (Searle 1988:151-152). They could by no means be considered representative of the nursing profession. The 1911 census had indicated that South Africa had approximately 1300 trained nurses working in public hospitals, as well as about 400 working in private practice. The number of untrained and unregistered practitioners was not known (Marks 1994:66).

SATNA's first meeting was held on Wednesday 27 January 1915 at 8 pm at Frere Hospital in East London, Eastern Cape. On that day, with approximately 30 members and guests (which included four doctors) present, the Border Branch of the association was established (SATNA 1915a:111; Searle 1965:242). Due to financial constraints, the SATNA's first chairperson, Miss Joan Schweitzer (the Matron in East London Hospital), was also appointed as Honorary Secretary and Treasurer (Trained Nurses' ... 1914a:419). Present as advisor at that first and many of the subsequent inaugural branch meetings was Dr John Tremble (Searle 1965:241-243; Searle 1982a:17-19; Trained Nurses' ... 1914a:420).

Early evidence of the philosophy that would guide SATNA's (and later SANA's) professional activities was evident in the speech that Dr Tremble delivered at the first meeting in East London. He lamented the fact that South African nurses, in comparison with countries such as the USA, New Zealand, Australia and India, did not already have an established nurses' association. He believed the Australasian Trained Nurses' Association, which examined, registered and managed the affairs of nurses in that vast country, to be "a model of all that an association can be" and further stated that "no woman can be a trained nurse and not be a member of it" (SATNA 1915a:112).

Dr Tremble highlighted the fact that in South Africa, with its smaller population, the examination and registration of nurses were controlled by the Medical Councils and the state. Although prominent politicians such as General JC Smuts were not opposed to nurses' representatives on the Medical Councils, no one was sure how to achieve this, because nurses had no unified, professional voice which could speak on their behalf. This, Tremble stated, was why the establishment of SATNA was so important. SATNA (as a collective) would have the power to address trained nurses' concerns if the majority joined the association (SATNA 1915a:111-112). Tremble created a draft constitution for

SATNA which was inspired by those of the British Medical Association and the Australian Trained Nurses' Association (Searle 1965:241-242).

SATNA brought a measure of order to a previously disorganised and professionally voiceless group of nurses. The *South African Nursing Record* (Trained Nurses' ... 1914b:14) stated the new association's aims:

- To weld the nurses of South African into a united band of workers
- To encourage co-operation and to take united action in the protection of the interests of the profession
- To encourage and maintain in every way the highest ideals of nursing in South Africa
- To hold social and professional gatherings whenever necessary or expedient, to discuss all matters appertaining to or affecting the interests of the profession
- To take such steps towards the formation of Benevolent Funds or Pension schemes as may be thought necessary
- To become more actively united by means of similar nurses' organisations in other countries with the members of the profession throughout the world
- To take all possible steps to suppress the practice of nursing by unqualified women and to prevent the abuse of the nurse's uniform

This initial list of aims was later amended to include (Searle 1982a:18-19):

- The furthering of South African nursing interests by legislative means
- The protection of nurses' rights, status, interests and privileges
- The provision of a trained nursing service that benefits the public

Considering the hospital-based nursing training disorganisation of the early 20th century, SATNA's membership requirements and nurses' desire to partake in the professional decision process, the inclusion of matters pertaining to policy development and training was essential. Directing the training and management of nursing affairs was cited as a rationale for nurse representation on the Medical Councils (Editorial Notes 1915b:30; Report Medical Inspector ... 1914:315).

Secondary sources (Marks 1994:119, Searle 1965:242) state that SATNA's constitution limited membership to White female registered nurses only, but the first bye-laws, printed in the November 1914 *South African Nursing Record* (one month after the SATNA was established), did not contain any reference to race (Trained Nurses' ... 1914c:36). Further, no *Nursing Record* issues of the first year (1914–1915) called for a racially exclusive membership. When changes to the bye-laws were proposed in 1917, the issue of male membership and the division of branches into two classes (namely midwives and nurses: this proposal was rejected by the Board) were evident – but still no reference to race was evident (Bye-laws of ... 1917:65-68; Bye-laws of ... 1918:177). A matter that was strongly emphasised was that SATNA members had to be state-registered nurses and not only trained nurses. The first bye-laws stated that “[T]he eligibility for membership shall be registration as a general nurse or midwife in any Province of the Union of South Africa, and no nurse not so registered shall be admitted to the Association” (Trained Nurses' ... 1914c:36). Men were excluded because it was felt that their scope of practice differed from that of female registered nurses (Meeting Executive Committee 1919:111). Numerous discussions about the role and position of trained but not state-registered (therefore not eligible for membership) Black and Coloured nurses were evident in the *Nursing Record*. It is evident from these articles that SATNA focused on establishing an association which membership consisted of the educated elite. When the SATNA was established in 1914, South Africa had only two Black registered nurses (Mashaba 1995:12, 14), and such a small number probably did not warrant a specific reference to race in the bye-laws. The researcher deduces that it might be possible that the “whites only” membership referred to in the secondary sources was initially not formalised in writing, but was rather the result of the early 20th-century social class system and notions of racial guardianship (note sub-sections 5.3.1 and 5.4.1 of this chapter).

Race-conscious statements appear to be formalised in documents only in later years, of which the SATNA bye-laws revised in 1937 were an example. The membership section of the 1937 booklet states that trained and registered nurses “whether European, non-European or Coloured, in the Union of South Africa, in Great Britain, or in any Dominion or Colony in the British Commonwealth where state registration is in force...shall be admitted to membership of the Association” (University of the Free State 1937:8). The bye-laws then stipulate that Black members had to be allocated to a separate branch, supervised by a White branch. Black and Coloured nurses were therefore allowed to be members of SATNA but – true to social Darwinism beliefs – had to be supervised.

The SATNA steering committee (the Central Governing Committee) decided that their membership requirement signified a matter of principle, because state recognition (government approval) suggested that all those practising nursing in South Africa should be registered. Such a well-regulated system would not only protect the rights of trained registered nurses, but also protect society against the ministrations of untrained nurses. SATNA was further of the opinion that a group of state-registered nurses would have greater political influence (TNA ... 1915:188-189; Trained Nurses' ... 1914c:35-36). An analysis of the name list of the first Central Governing Committee (Searle 1982a:17-19, 248) suggests that members were mostly English-speaking matrons. This dominance would later contribute to the dissatisfaction of Afrikaner and student nurses with SATNA. Initially nurse probationers were considered for membership, but that idea was rejected. However, to commence with the professional socialisation of the nurse probationers, they were offered the *South African Nursing Record* at a reduced price and encouraged to join SATNA immediately after completion of their training and subsequent registration (Trained Nurses' ... 1914b:13).

SATNA held its first Central Governing Committee meeting on Monday, 8 November 1915, in the lecture room of the Johannesburg General Hospital. Eight nurse delegates met for two days. Sent by one of the branches as a delegate to the meeting and acting as advisor was Dr John Tremble. Although he took a leading role in the early days, this gradually changed. By 1926, he attended SATNA meetings in an advisory position only, not as a delegate and with no voting powers (Alexander 1926:936; Searle 1982a:20-21). This illustrated the gradual change of women's status in society and that nurses (still with the assistance and support of men such as Dr Tremble) were coming to understand the principles of professionalism and defining the role(s) of nurse leaders (Harrison 1982:5; Searle 1987a:297-298).

The first meeting of the Central Governing Committee decided to rename itself the Central Governing Board (Harrison 1982:5). The first President-elect of SATNA was Miss Mary E Nutt, R.R.C. (Royal Red Cross – exceptional service in military nursing) and O.B.E. (Order of the British Empire), then Matron of the Old Somerset Hospital in Cape Town. Miss BG Alexander was elected to the office of Honorary General Secretary and Treasurer (Searle 1982a: 20-21; 24-25; 93-96). Within a year of being established, SATNA was the acknowledged body representing the nursing profession (Searle

1965:244; Searle 1987b:279). In contrast to Miss Hannah's failed association, SATNA obtained recognition from the government. Traditionally, the wife of the British Governor-General of South Africa was invited to be the Patroness of the Association. Women such as Viscountess Buxton (1915–1920) and HRH Princess Arthur of Connaught (1920-1923) took up the role (Searle 1982a:20-21, 25-27). This illustrates a level of political astuteness which safeguarded SATNA's continued existence.

In 1920, SATNA's Central Governing Board adopted a Memorandum and Articles of the Association, which enabled it to register its title and badge. To register under section 21 of the 1909 Company Act (31), a fixed number of shares was required. Five nurses and two doctors each received and held seven £1 shares (Searle 1982a:24; University of the Free State 1937:3-4). By using a historical inflation rate calculator (Morley [Sa]) and the current (28 October 2016) exchange rate for the South African Rand and the British pound, it is calculated that in 2016 seven £1 SATNA shares were worth ZAR 5 507,46.

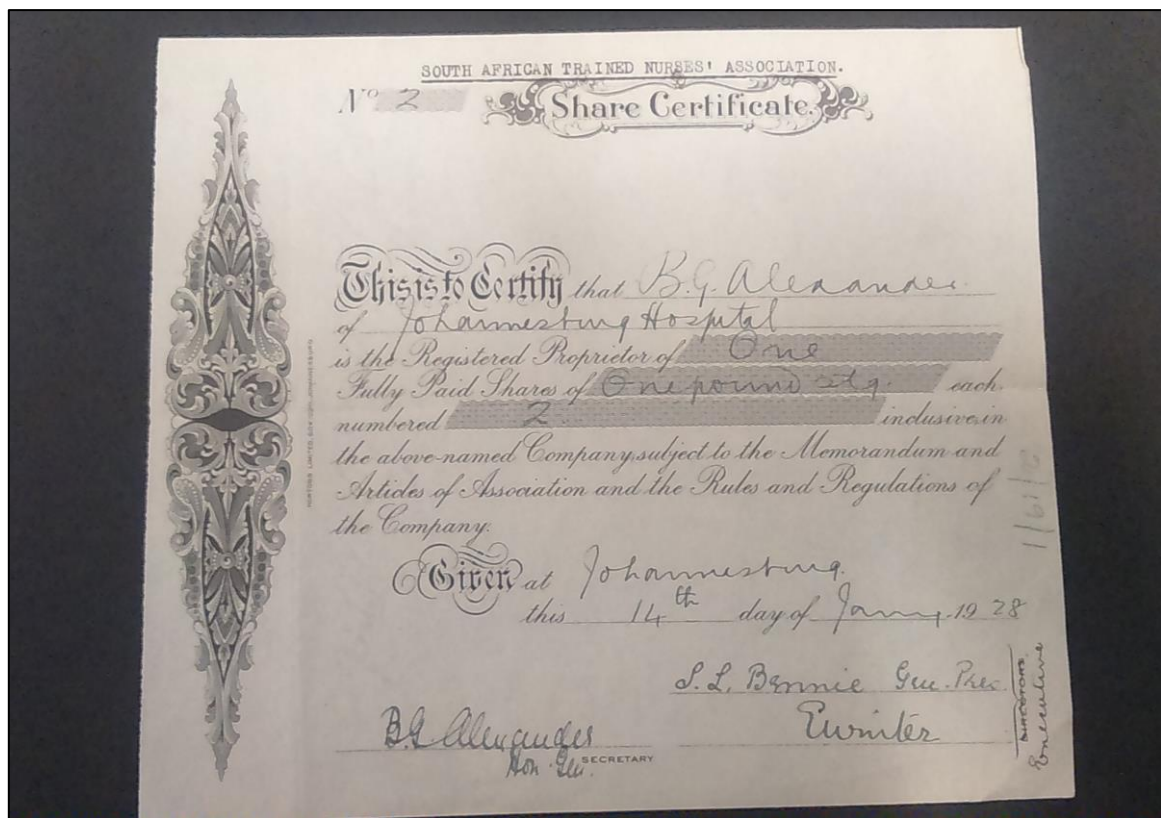


Figure 5.2 Miss BG Alexander's SATNA share certificate
(University of the Free State 1928)

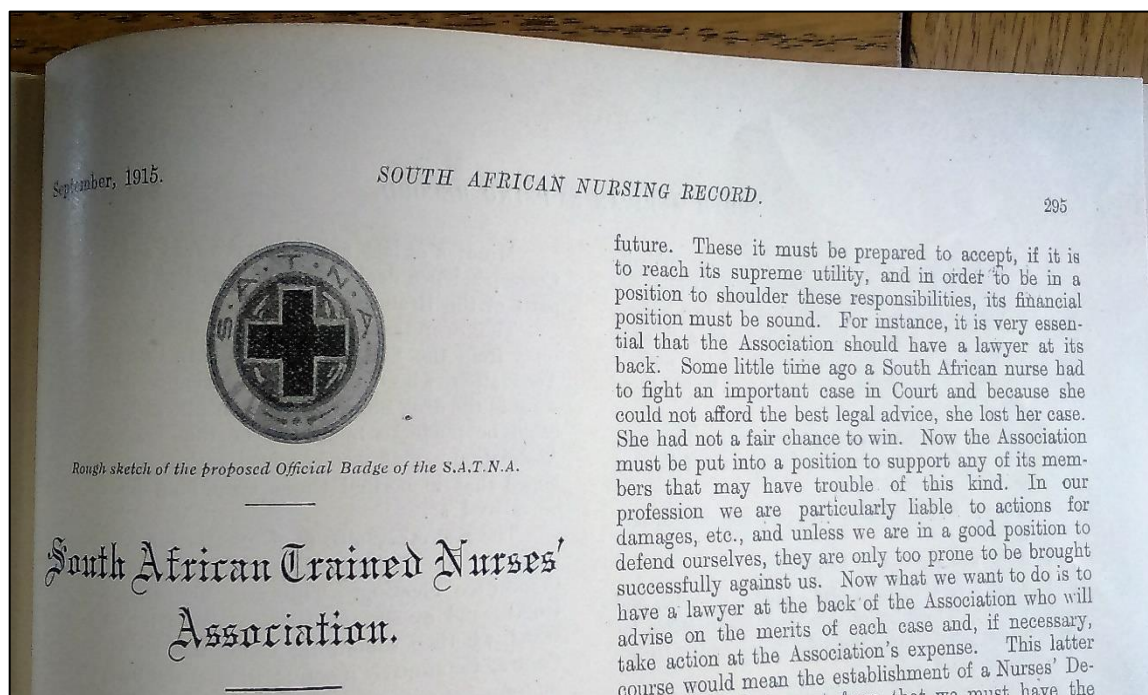


Figure 5.3 The proposed badge for SATNA members
(SATNA 1915b:295)



Figure 5.4 Commemorative coin for state registration of South African nurses: 1891–1991
(Owner: the researcher)

5.2.3 SATNA: success and limitations

The socio-economic state of the country and the fact that women were entering the workplace in greater numbers (due to the Industrial Revolution and WWI) possibly emboldened nurses and their supporters, especially in the light of the first aim listed in SATNA's declaration of intent: the creation of a united group of workers. Compulsory (not voluntary) registration, an own nursing council and the promotion of locally trained nurses to senior positions were also matters of priority. When a new Medical Bill was drafted in 1923, SATNA and its supporters in the medical fraternity campaigned to have two nursing representatives included in the planned Colonial Medical Council (which would replace the four provincial Councils). Under the South African Medical, Dental and Pharmacy Act (13 of 1928), two nurses, Miss BG Alexander and Mrs LL Bennie, joined the new Medical Council (Marks 1994:121, Searle 1982a:16, 18-19, 36-37; Searle 1965:245). Considering that the South African nurse leaders of the time were predominantly English, it is worth mentioning that Mrs Bennie was a South African-born and trained nurse.

During the WWI (1914–1919) years, SATNA very early on established a fund to take care of nurses doing war duty. The Nurses' War Memorial Fund provided financial support, created a sick fund and provided a holiday home for the weary. The 1918 Nurses' Relief Ordinance ensured better working hours, and for those who took advantage of the improved leave conditions there were railway concessions which assisted them in their travels (Alexander 1926:936; Radloff 1970a:24-26).

Radloff (1970a:32) explains that SATNA had several challenges to overcome. These included insufficient finances and the fact that not all nurses were interested in the association. A small group of nurse leaders bore the burden of not only managing their huge workloads, but also finding time for SATNA activities. Additionally, these women battled "prejudice against the role a women's group was playing" (Radloff 1970a:32). Although not representative of all South African nurses, SATNA nevertheless involved itself in numerous professional activities on behalf of all nurses, regardless of membership status (Harrison 1982:5; Radloff 1970a:39).

The *South African Nursing Record* (VAD Probationers ... 1917:62) confirms the value and influence of SATNA within the first three years of its existence. There was progress in its drive to have compulsory registration for trained nurses and in prohibiting the

practice of unqualified nurses. SATNA also influenced the training standards that VAD nurses (Voluntary Aid Detachment members who assisted the injured during WWI) had to comply with before registration, and it advocated the appointment of nurse and midwife examiners (Meeting Executive Committee ... 1919:111). Later, its political influence was evident in its campaigns to have nursing representatives on the 1928 Medical Council, and its petition to the Minister of Health to ensure nurse representation on the Parliamentary Commission on National Health Services (Searle 1982a:41).

By 1942, SATNA represented approximately 1600 of the 13 000 nurses practising in South Africa. The association had evidently failed to attract all registered nurses to its cause. It could certainly not claim to represent all nurses in the country, as its membership was limited to registered nurses only. Those still in training (student nurses) and the hospital trained (e.g. Black nurses) established separate associations, affiliated with SATNA. After the SA War, Afrikaans-speaking nurses also did not feel welcome in a predominantly English environment. Such divisions contributed to SATNA's inability to address and solve the profession's problems. Younger nurses and male nurses became dissatisfied. In March 1919, a male nurse wrote a letter to the *South African Nursing Record* objecting to the exclusion of men from SATNA. He suggested that the Association change its name "to the S.A.T.F.N.A., the 'F' meaning, of course, female. This will differentiate between the two in the event of the male nurses forming a similar association" (Correspondence 1919:111). It would require the 1942 trade union crisis to force change in SATNA (Du Preez & Brannigan 1991:38; Rispel & Schneider 1990:30; Searle 1965:244, 246-248).

5.2.4 The relationship between SATNA and the Medical Councils

Although South African nurses from 1928 onwards had two representatives on the unified Medical Council, the medical fraternity still controlled nurses' professional affairs (e.g. disciplinary action, examinations and registration). The two nursing representatives could vote only on nursing matters (Kotzé 2013:64-65). Furthermore, due to the shortage of nurses in the country, untrained nurses and midwives could continue their practice. Such constraints irked the liberal-minded, female SATNA leaders, who complained of being treated as minors. This provided the impetus to campaign for an increased representation on the Medical Council's Nursing Committee or, alternatively, an own regulatory body in the form of a nursing council (DENOSA 1938:2; Third Annual ... 1918:149). SATNA's

1938 and 1943 efforts in this regard were, however, unsuccessful. The Secretary for Public Health, wishing to avoid a “protectionist” nursing council (as had happened in Britain) and citing unrealistic requirements of nursing candidates (which exacerbated the nursing shortage), opposed the idea of nurses having a greater say in nursing matters. Not even support expressed by SATNA members in a referendum could sway his opinion (Marks 1994:121-122, 124-125; Radloff 1970a:30).

Not all medical doctors were reluctant to welcome nurses to the fold. At their first attendance at a Medical Council meeting (22 October 1928), the two nurse representatives were welcomed by Dr DF Malan, the then Minister of Interior, Education and Public Health. He confirmed that it took the male members of society long to realise that it was predominantly women who took care of society’s sick – and that they should therefore have a say in the formulation of public health policy (Searle 1965:245). Other influential medical men such as Dr Ronald Mackenzie, Superintendent of Johannesburg General Hospital and member of the Transvaal Medical Council, supported nurses in their endeavours (Searle 1965:243). University of the Witwatersrand professors Raymond Dart and Philip Tobias advocated for sister tutor training at university level (Horwitz 2011:2). The ardent nurse champion Dr John Tremble referred to the “trinity of medicine, nursing and pharmacology” and emphasised that the three professions acted interdependently. He did, however, view the doctor as the leader in the health-care environment, there to guide the other two professions to maturity. His ideal for South African nursing was expressed in the February 1915 *South African Nursing Record* (Traditions 1915:107) as follows:

“You young nurses in this young and promising country of ours, we wonder if you know how fortunate you are. For your traditions are still to build, and it is for you to build them...what an opportunity you have got, not merely to follow in others’ footsteps, but to give the lead and set the pace ... do not be content to be merely ordinary, be more than that.”

When the legislative bill proposing the formation of a Union Medical Council to replace the four provincial Medical Councils was introduced in parliament in 1917, SATNA called for representation on that new Council (Adequate protection ... 1916:117; Representation on Medical Councils ... 1916:94; Medical & Pharmacy Bill 1917:66-68) as well as an independent midwifery board. In a letter dated 3 August 1917, published verbatim in the

September 1917 *South African Medical Record*, the SATNA secretary summarised the nine resolutions adopted at the association's annual meeting. Resolution no 2 dealt with the establishment of a central midwives' board and explained that their call came due to the increasing numbers of midwives in South Africa. References were also made to the recently established British Midwifery Board and its positive effect on the profession (Alexander 1917:282). SATNA's call was in line with its aim of furthering and protecting nursing interests by legislative means.

The 1917 annual SATNA meeting's acceptance of resolution 9 was also in line with its aim of preventing untrained and unregistered nurses from practising, and striving to raise nursing standards. It was also a means of defending the registered nurses, who were subject to disciplinary action by the Medical Councils, while practising unregistered nurses were not (Report Medical Inspector ... 1914:315). Resolution no 9 suggested that a standardised uniform and "a distinctive armlet or brassard" (Alexander 1917:283) for trained nurses should be implemented. The wearing of such distinguishing devices would be illegal for untrained persons. (In fact, the wearing of a distinguishing badge for trained nurses and midwives had been proposed shortly after the founding of SATNA (Suggestions to improvements ... 1914:354)).

The importance of training standards was further expressed by four additional resolutions which addressed training issues such as preliminary schools for nurse probationers, the required length of training, and the training of Coloured nurses and VAD nurses (Alexander 1917:292-283; British Red Cross 2016; VAD Probationers ... 1917:61). A further appeal not to employ unqualified nurses was made in a 1920 letter written by the SATNA General Secretary and addressed to the Witwatersrand branch of the BMA. The letter requested the doctors to assist in this matter as the nurses "have no redress by law" (British Medical Association 1920:254).

The 1917 Medical and Pharmacy draft Bill did not pass through Parliament, but was deferred by the Minister of Public Health, due to what the *South African Medical Record* calls "medical politics" (Unpopular Profession 1919:51). Such politics included dentists' requesting a separate Dental Council and the midwives of South Africa campaigning for the establishment of a midwifery board (Searle 1972:230; Medical and Pharmacy Bill 1917:65; Unpopular Profession 1919:51). The medical fraternity considered these requests as "positively mischievous and calculated to block the way of legislation as well

as to impede the operation of administration” (Multiple Medical Councils 1918:97). Independent-minded doctors and nurses striving for a distinct professional voice were bound to have conflict. SATNA had to deal with the four provincial Medical Councils until 1928 (Mellish 1990:126; University of Witwatersrand 1934d).

A draft Medical Bill was introduced in 1923, this time proposing that provincial Medical Councils be unified into one governing body *and* that nurses be represented on such body (Alexander 1926:935-936). The bill passed through Parliament and became the Medical, Dental and Pharmacy Act (13 of 1928), thus establishing the South African Medical and Dental Council (SAMDC) which included two nurse representatives (HPCSA 2016; Marks 1994:121; University of Witwatersrand 1934d). Searle and Pera (1993:13) state that nurses gained much from serving on the Medical Council Board because they acquired an understanding of professional ethics, such as the ethical considerations that should guide the relationship between doctor, nurse and patient.

The solemn paternalistic relationship between SATNA and the Medical Councils was occasionally disrupted, as the journal excerpt below illustrates:

The grave solemnity of the proceedings of the Cape Medical Council was divertingly broken at the last meeting by a letter from a lady asking the Council to assist her to obtain a certificate of training from the principal of a Midwifery Training School, which that principal refused to give, a dispute having occurred between the parties, mainly owing, as the correspondent averred, to the principal being the owner of a temper and a cat. The latter could hardly have been a maternity patient, as the letter contained internal evidence to the effect that it was a Tom cat. In any case, according to the complainant, one of the duties of the midwifery pupils was to take the said cat for promenades, see it comfortably settled in bed, and otherwise attend to its multitudinous wants, a duty to which the writer took profound objection, as she did also to doing the hair of the principal and otherwise acting as a *femme de chambre*.

The result of all these differences of opinion as to the scope of the curriculum laid down by the Medical Council was anything but a Peace League, the aggrieved pupil being peremptorily told to "git" a fortnight before the conclusion of her six months, minus certificate of cases and lectures.

Figure 5.5 The Council, the midwife and the tomcat

(Passing Events 1919:221-222)

This snippet effectively illustrated the professional vulnerability of nurses and midwives in the early 20th century. Training opportunities for student midwives were scarce, and at profitable nursing homes they were expected to pay for their education. Furthermore, before the existence of professional organisations to protect their rights as workers, nurses could be dismissed at will (Radloff 1970a:11-12). No protective bargaining body existed to speak on behalf of the student midwives (who were clearly exploited by the principal of the above maternity school). The student nurse had to appeal to the provincial Medical Council. Nurses' powerlessness and the need for their own nurses' council or representation of the Medical Council was also commented on by SATNA Board (Third Annual Meeting ... 1918:149).

5.2.5 South African membership of the International Council of Nurses

In line with its aim to connect with other professional organisations through the world, SATNA officially became a member of the ICN on 22 May 1922 at the International Nurses' Congress in Copenhagen (Alexander 1926:973; Searle 1972a:246-247). Although Henrietta Stockdale had been a founding member of the ICN in 1901, South African nurses could not join that international body earlier, because they did not have a dedicated nurses' organisation. Before 1922, South African nurse leaders only attended ICN meetings as observers (Searle 1972a:247, 238). The ICN provided an international platform where nurses could debate issues related to nursing training and the functions of the professional nurse (Harrison 1973:7).

The outbreak of WWI (1914-1919) further delayed ICN membership, though SATNA was established at the beginning of that war (Searle 1982a:28; Searle 1972:247). Introducing the first President of SATNA, the author of a 1916 *British Journal of Nursing* article optimistically stated: "We are looking forward to the South African Association taking its place in international co-operation with Europe, Asia and America at the next meeting of the ICN at Copenhagen in 1918, if peace then reigns instead of war" (First President ... 1916:187).

After joining the ICN in 1922, SATNA leaders actively participated in international nursing affairs. They attended international conferences, and by July 1926 were participating in international standing committees deliberating on nursing education and public health matters. SATNA's continued participation in the Florence Nightingale International Foundation (for postgraduate nursing education) was rewarded when Miss BG Alexander (R.R.C.) was elected its World President in 1939. Miss Alexander (SATNA President) was instrumental in extending South African nurses' professional activities nationally and internationally. She was twice elected Second Vice-President of the ICN (in 1933 and 1937), as well as First Vice-President in 1941 (Mellish 1990:132; Searle 1982a:28-29).

5.2.6 The SATNA's professional activities

At the outbreak of WWI (1914-1919), SATNA was a small professional nurses' association attempting to foster unity among trained, registered nurses across Southern

Africa. Its long-term goal was the establishment of a professional nursing service, managed autonomously by nurses for nurses.

The members involved themselves in the educational advancement of nurses by means of recommendations to the Medical Councils (DENOSA 1934:1-6). One such representation was to have the first Nurse Examiner (by the name of Miss HOI French) appointed in 1916 in the Transvaal (before then, all nursing examinations were conducted by medical doctors). SATNA also strove to have nursing degree courses established at South African universities. In this, they were not successful, due to funding problems and academic reluctance to accept the idea of nurse training as a tertiary course. The first nursing diploma course would only be presented in 1937 by the University of the Witwatersrand, while the first basic nursing degree would commence in 1956 at the University of Pretoria (Horwitz 2011:2, 4; Marks 1994:63; Searle 1982a:30-31).

SATNA's advocacy for improved nursing education was important, because student nurses were considered a cheap labour force in the early 20th century. Radloff (1970a:9-10) states that nursing education "was merely a by-product of hospitalisation". Hospitals only trained to meet their staffing needs sufficiently. The result was that not enough nurses were trained to meet the health needs of South African society. Public health services were barely functional and district nursing was conducted by charitable societies. Hence, overseas nurses had to be recruited (Radloff 1970a:9-10; Report Medical Inspector ... 1914:314).

From its conception, SATNA's official voice, the *South African Nursing Record*, endeavoured to communicate information and encourage a research philosophy in the profession. The 1913-1916 issues all contain editorial discussions about important professional nursing matters, news from the SATNA branches and the Medical Councils, book reviews and articles about specific diseases, types of surgery and "cooking for the sick". In October 1935, on its twenty-first birthday, SATNA replaced the *South African Nursing Record* with its own scientific research journal, titled the *South African Nursing Journal* (Searle 1982a:39).

5.2.7 SATNA's socio-economic and community activities

The idea that nurses were doing charity work and therefore did not require payment was derived from the religious sisterhoods. As early as 1875, such nurses received uniforms, free accommodation, food and a small stipend. That arrangement had a negative impact on nurses' economic status. In the 19th century, nurses as hospital workers were the lowest-paid category; for example, a matron received about a fifth or a sixth of what a storekeeper or clerk received. Before 1910, only nurses in the Cape Province had access to a pension fund and the retirement age for nurses was 70 years (Radloff 1970a:6-8; Report Medical Inspector ... 1914:314). SATNA consequently busied itself with nurses' welfare by creating several social assistance funds, such as a sick fund (1918), a pension fund, a WWI equipment fund (later renamed the Lady Crewe fund) and provincial Nurses' War Memorial funds (after WWI), which assisted aged and incapacitated nurses. By 1923, nurses had access to a holiday home, while retired nurses could by 1930 make use of the Homes for Aged Nurses. Nurses' rights as workers also received attention, with SATNA promoting the appointment of South African trained nurses to senior positions and assisting them with salary matters, pension fund facilities and improved leave benefits (SATNA 1920:398; Searle 1982a:31-34).

The community received attention, with SATNA playing a significant role in the establishment of the National Council of Child Welfare and urging the appointment of trained social workers in hospitals (Searle 1982a:38-39). The 1937-1938 financial report illustrated that SATNA budgeted to pay affiliation fees to the National Council of Child Welfare as well as to the National Council of Women (NCW) (DENOSA 1938:3). In later years, SANA would continue this community involvement, with a 1947 survey indicating that nurse leaders were involved in numerous social welfare organisations (Radloff 1970a:27-28).

5.3 SOCIAL CLASS, EDUCATION AND NURSE TRAINING

Although South African political parties only formalised segregation policies after WWI (Brits 1993:207; Welsh 2000:394), segregationist attitudes were evident even before to the war. A discussion about such social influences, which contributed to the establishment of the BTNA, is required.

5.3.1 Social class and Western-style education

Early 20th-century society determined social standing based on a person's economic status (rich or poor) and level of formal Western-style education. In colonial South Africa, this British class system was transformed when race became an additional classifier of social status. Black people were relegated to the lower social classes due to their perceived non-compliance with Western standards of wealth and education (Esterhuizen 2012:44; Marks 1994:4).

Although the Medical, Dental and Pharmacy Act (no 34) of 1891 had made provision for the registration of trained nurses of all races (Sweet 2004:179), in Southern Africa no persons of colour were registered as professional nurses in the last years of the 19th century. As stated earlier (note Chapter 4, sub-section 4.2), British nurse leaders strove to establish nursing as a profession for educated women and therefore demanded high educational and socio-cultural standards of their probationers (Macvicar 1915:8-9). Only in 1908 would Cecilia Makiwane become the first African woman to add her name to the register of trained professional nurses (Searle 1972:271).

5.3.2 Training for African nurses

In the early 20th century, South Africa's health care system was inadequate, and in Black communities especially, there was a dire need for primary health care services. More nurses were urgently required; the few white nurses were simply not enough. By 1912, the matter of training of Coloured and Black nurses (and the social anxiety about race relationships) were brought to the fore. The debate would continue until the 1930s. The second edition of the *South African Nursing Record* discussed the matter at length and concluded that a system of training for Coloured and Black nurses was desirable, as they were of great assistance in areas such as community care, mine hospitals and small rural hospitals. SATNA's mouthpiece conceded that there were varied opinions about an acceptable training and registration system for such nurses. Its own opinion at that time was that hospital training awarded the nurse with a hospital certificate that "actually carries no weight" (Certification of ... 1913:56). The *Nursing Record* rather preferred a state (government) controlled system of training and lower grade certification because it would provide nurses with official status (Editorial Notes 1915a:256; Report Medical Inspector ... 1914:315; Certification of ... 1913:56).

Articles in early editions of the *South African Nursing Record* (Editorial Notes 1915a:256; Certification of ... 1913:55-56; Certification of ... 1915:12-14) and in 1917 and 1918 issues of the *South African Medical Record* and the *South African Nursing Record* effectively illustrated colonial society's perception of social class, its influence on SATNA and by extension on the nursing profession. The journal articles discussed below illustrate SATNA's endeavours to promote a high standard of nursing education that would have ensured its members professional exclusivity.

5.3.2.1 Training of Coloured midwives and nurses

In March 1917, the Cape Medical Council responded to letters received from the Marion Institute for Coloured Women in Cape Town about the establishment of a training school for midwives. The Council declared that it was not able to provide training facilities but confirmed "that the Council knew no colour bar in these matters, and that all persons satisfying the Regulations were equally eligible for examination and licence" (Cape Medical Council 1917:73).

A few months later, on 3 August 1917, the SATNA General Secretary, Miss BG Alexander, wrote a letter (published in September 1917) to the *South African Medical Record* informing its readers of the resolutions adopted at SATNA's annual meeting. Resolution no 4 recommended the extension of all nurses' training, due to nurses receiving more leave and due to the "increased amount of knowledge a nurse is expected to have" (Alexander 1917:282). The SATNA Board also adopted resolution no 1 after the Transvaal Medical Council recognised a Midwifery School for Coloured nurses and allowed the training of Coloured nurses at the Crown Mine Hospital in Johannesburg. SATNA requested that the provincial Medical Councils clarify the position and status of Coloured nurses as "such nurses, if not properly controlled, constitute a very grave menace to the white nursing profession" (Alexander 1917:282). It was recommended that nurses of colour should receive mostly practical training over a longer period (three years) and then be awarded a second-grade certificate, which did not entitle them to state registration under the system then in place. Furthermore, if they wished to sit for a Medical Council examination and register as trained nurses, the duration of training should be four (or even five) years. The reasons given by SATNA for these recommendations were that mine hospitals were not training schools, as they had only male patients. Yet the concern

was also raised that if Coloured nurses started work in general hospitals the training opportunities for White nurses would be reduced (Alexander 1917:282; Editorial Notes 1915a:256). Lastly, it was feared that the introduction of Coloured nurses in smaller hospitals would lead to a fall in nursing standards. The motivation for resolution no 1 is concluded: "The [SATNA] Board considers this the absolute minimum of restriction in order to avoid the unfair competition on the part of the native women which would be bound to follow anything more lenient" (Alexander 1917:282).

SATNA communicated these resolutions in the July 1917 edition of the *South African Nursing Record* and implied that the medical fraternity agreed with resolution 1. The *South African Medical Record* swiftly denied it: "we can assure our contemporary that there are a good many members of Medical Councils who will take a long time to be converted to the utterly illiberal and outrageously racial trade unionism of the TNA on the Coloured nurses' question" (Coloured Nurses ... 1917:351). The lead article in the January 1918 *South African Medical Record* and further articles (published in February) continued the debate, evidently after more communication took place between SATNA and the medical fraternity. The Medical Councils could not accept that qualified Coloured and African women would corrode nursing ethics and status. It was felt that every nurse should be judged on her conduct rather than her race (Second Grade Certificates ... 1918:49-50; Second Grade Nurses 1918:33; Trained Nurses' ... 1918:2-3). Gelfand (1984:97) confirms that the Colonial Medical Council was not swayed by the SATNA objections, and so the first training school for Coloured midwives, St Monica's Home, opened its doors in Cape Town on 10 April 1917. The first fully trained Coloured nurse, Georgina Judson, registered in January 1918 (Radloff 1970a:98). SATNA seems to have reconsidered its position, as its Central Board later called on the state to increase and support the training of white and Coloured midwives (Third Annual Meeting ... 1918:149).

5.3.2.2 Lesser trained nurses

Miss Alexander's 1917 letter demanded that a decision be made regarding the training, certification, and management of lesser trained and subsequently unregistered nurses – a debate that had commenced soon after SATNA was established. In the October 1915 edition of the *South African Nursing Record*, the issue was debated in the form of three articles. Dr Darley-Harley (editor of the *South African Medical Record*) and Dr Neil Macvicar (missionary and educator from Victoria Hospital, Lovedale) explained their

opposition to a lower-grade certificate for nurses of colour. In the third article, SATNA recognised the urgent need to train more Coloured and Black nurses, stating that the then current system of allowing trained, registered *and* untrained, unregistered persons to work as nurses was unfair. According to the *Nursing Record*, such an inconsistent nursing care system was problematic and created greater competition amongst nurses than would a system which required all nurses to be registered, albeit some at a lower grade. The *Nursing Record* further explained that the urgent need for more nurses of colour was hampered due to the Westernised educational standards required of them. The solution was to present the same curriculum to all nurses, but to conduct a theoretical examination with fewer anatomy, physiology and pathophysiology questions for the nurses of colour. The focus would therefore be on practical competency, hence the lower-grade certificate. The *Nursing Record* conceded that such a lower-grade certificate should be a temporary solution and that it should in later years be reconsidered. The implications of a lower-grade certificate were that the holders would be limited in their scope of practice and (like registered nurses) controlled by state registration (Darley-Hartley 1915:7-8; Macvicar 1915:8-10; Certification of ... 1915:12-14).

A year later, the *Nursing Record* acknowledged the prevailing nursing shortage, but reiterated that untrained, partially trained and/or unregistered nurses of colour should not be allowed to work. SATNA posed no objection to the training and registration of Black and Coloured nurses, and stated that the “native nurse has come and is going to stay” and that it was time to put their training on “sound footing” (Coloured patients ... 1916:144). The association then stated: “Let them have their native nurses by all means – only let them be nurses, trained, certified and recognised as such” (Coloured patients ... 1916:144).

SATNA received criticism from within its own ranks. In December 1917, the *South African Nursing Record* acknowledged Nurse LL Bennie’s reproach of SATNA’s apparent objection to Black and Coloured nurses receiving full training. The *Nursing Record* agreed that there was a shortage of such nurses to care for Black and Coloured patients in “the Territories”, and reiterated that it had no objection to such nurses receiving full training. The problem was, however, that there were not enough Black and Coloured nursing candidates who complied with the educational standards required to enter full training – and thus registration. The nurses being trained at mine hospitals were not receiving full training (as they were not exposed to all the practical fields of nursing: e.g. nursing of

women and children) and they could therefore not become trained, registered nurses. The *Nursing Record* therefore asked that these nurses' curriculum, examination and registration be defined – which implied a different qualification. In the *Nursing Record's* opinion, such lesser trained nurses could work “under white supervision” in specific areas such as mines and districts where no trained nurses were available. Although not the ideal, such a system could, in their opinion, alleviate the nursing shortage (Training of ... 1917:59; Third Annual Meeting 1918:149).

5.3.3 The price of educational and professional exclusivity

Owing to the early 20th century SATNA leaders' close ties with British nursing (Searle 2001:9) and the ICN (as illustrated above), the researcher accepts that South African nurse leaders were influenced by female professional ideologies. Nurses' scientific knowledge and professional positions set them apart from other working-class women – and in South Africa created social and racial exclusivity (Marks 1994:5-6). This is evident in SATNA's membership, which was limited to trained (elitist education) females (exclusivity). It provided financial assistance to its members in times of illness (Alexander 1926:937). In its first edition, the editor of the *South African Nursing Record* stated that it was an important principle that the interests of trained nurses should be protected at all costs. Therefore, “it is impossible to over-estimate the importance of a rigid exclusiveness in the registration of trained nurses” (Editorial Notes 1913:7).

The drive to create such exclusiveness expressed itself in SATNA's stance about the training of lesser qualified nurses (note sub-section 5.3.2.2) and in its insistence that the VAD nurses complete further training before being registered. At the third annual SATNA Board meeting, concerns were also raised about “white women with inferior education” (Third Annual Meeting 1918:151), who might want to take advantage by entering nursing by means of the lower-grade training system. The argument in all these cases was that the high standard of nursing should be maintained, and that the shortage of practical skills in the hospital was a concern. SATNA wanted the “avoidance of injustice” to probationers already in training (VAD Probationers ... 1917:61). In later years, this exclusivity contributed to raising the image of nursing and establishing principles of professionalism (Mellish 1985:23-24).

British nurses were especially protective of their position in the social order and, in the words of Soine (2010:72), “saw citizenship to be as much a privilege of class as of gender”. Issues such as women’s suffrage, nurses’ socio-economic welfare, racial superiority and an elitist education would have been considered important themes. They were therefore wary of any plans (such as insurance and pension plans) that would degrade nursing to the level of waged labour. This elitist stance at times made South African nurse leaders insensitive to the plight of overworked nurses. Dissonance arose between the elitists’ quest for professionalism (with its implied knowledge, expertise and social recognition) and the working-class nurses’ need to have working conditions and remuneration (wage-labour issues) addressed (Soine 2010:53, 61, 66-68, 70, 73). Rispel and Schneider (1990:25) argue that the drive for professionalism created social inequality among nurses. Black South African nurses had to establish their own professional association, while White student nurses considered a nurses’ trade union as a means to voice their frustrations.

In discussing the matter of training for Black and Coloured nurses, Marks (1994:90-93) states that the debate essentially revolved around the issue of nursing shortages on the one hand and professional status on the other. There was an insistence that giving Black and Coloured nurses the same training indicated respect for all races, but at the same time it kept the numbers that entered the profession in the early 20th century low, due to their lack of formal education. It is likely that white nurses, amid establishing nursing as a profession and getting women on an equal footing with men in the workplace, felt threatened by a group of nurses whom they perceived as being of a lower social class. Nevertheless, in South Africa, the establishment of nursing as an occupation with a distinct, organised professional voice came at the cost of future professional unity.

5.4 THE BANTU TRAINED NURSES’ ASSOCIATION: 1932–1944

In this section, the establishment of the BTNA, its aims, successes and limitations as a professional South African nurses’ organisation are discussed.

5.4.1 The establishment of the Bantu Trained Nurses’ Association

Colonial South Africa conformed with the British socio-economic class system, which was based on material wealth, Western-styled education and race. The founding members of

SATNA were British doctors and nurses. It is therefore reasonable to conclude that such early 20th-century British norms and values influenced even liberals. Colonial nurses were considered pivotal in anglicising the colony's local population. At the same time, the male-dominated society raised grave concerns about White women nursing Black men. Marks (1994:48) refers to the issue as "the racial etiquette of colonial society".

Based on this colonial class system, white people were considered superior to people of colour and thus there were objections to Black nurses (perceived as inferior) being trained (Gelfand 1984:278; Marks 1994:52, 146-147). Society's debate about the certification of lesser trained nurses of colour, which was aimed at alleviating the shortage of nurses in early 20th-century South Africa, would continue for many years. Based on a 1913 Cape Colonial Medical Council committee's finding, it was decided that lesser trained nurses would not be granted state registration. The decision was motivated by the implied economic threat that lesser trained nurses of colour posed to White nurses. It was thought that lesser trained nurses would provide a sub-standard, but cheaper, workforce. The Medical Councils' objections about a lesser trained category of nurse did not derive from pure altruism; it was also motivated by self-interest. If a lesser trained nurse became acceptable, it would have validated calls for a lesser trained *medical aid* to alleviate the shortage of medical doctors (Darley-Hartley 1915:7-8; Mashaba 1995:83-85; Searle 1965:270-272).

The discussion illustrates the fact that socio-political and educational factors resulted in slow progress with the training and registration of Black South African nurses. The first Black professional nurse, Cecilia Makiwane, registered in 1908 (Gelfand 1984:74; Searle 1972:271). By 1922, two female Black nurses and one Black midwife had passed the final examination for professional nurses and midwives (Searle 1965:273). Therefore, eight years after the SATNA's formation, there were only three professional Black nurses registered with the provincial Medical Councils. By 1942, a total of 160 Black students had passed the final examination for professional nurses and midwives in South Africa (Searle 1972:275). Large-scale training of Black and Coloured nurses only started after 1948, so that by 1972 the number had drastically increased. On 31 December 1972, there were 14 276 black registered nurses, 3 261 Coloured and Indian registered nurses and 26 135 White registered nurses in South Africa. This effectively illustrates that the debate about the training and registration of Coloured and Black nurses had delayed their entry into the profession and aggravated South Africa's nursing shortage.

5.4.2 BTNA: aims, successes and limitations

Secondary sources (Lubanga 2014; Searle 1965:242, 273) state that SATNA invited only state-registered White female nurses to join, excluding Black registered nurses from being members. Their exclusion compelled Black nurses to establish their own nursing organisation, the Bantu Trained Nurses' Association, on 25 November 1932. In the light of the fact that the 1937 SATNA bye-laws (note sub-section 5.2.2) confirm acceptance of trained, registered nurses of all races, the researcher deduces that SATNA's primary focus was standard of training and *state registration*. The BTNA invited all registered nurses and midwives, *as well as hospital certified* nurses, to become members (Du Preez & Brannigan 1991:37; Mashaba 1995:29; Searle 1965:273).

5.4.2.1 BTNA aims

Mashaba (1995:29-30) states that the aims of BTNA were:

- to assist those nurses who worked in isolated regions of the country
- to create a scholarship fund that could assist student nurses and post-graduate nurses with training costs

BTNA's aims, as explained by Searle (1965:273), differ in tone:

- to create a professional discussion forum which promoted cooperation amongst Black nurses
- to raise and maintain Black nurses' professional and moral standards
- to promote the professional and educational progress of Black nurses
- to improve the standard of nursing education for Black students
- to "co-operate for mutual protection professionally"

Searle (1965:273) concludes by stating: "Subscribing to these standards marked the point at which Bantu nurses had begun to adopt a professional outlook and to acknowledge the responsibilities which a profession imposes on its members".

Mashaba (1995:30) reflects: “Aspiring to such high ideals showed the extent to which black nurses had assumed the responsibilities that their profession imposed upon them – the process of professionalisation was well and truly established. This consolidated the black nursing force and strengthened their position”.

5.4.2.2 Successes and limitations

The slow increase in the number of trained Black nurses prior to WWII and the subsequent effect on membership was evident from the second annual BTNA minutes of meeting. While the secretary of BTNA urged all nurses to join the association, the President, Nurse Caroline Zondi, was pleased to report “an increase of one-third over last year’s numbers”. BTNA had 24 full members with more applications pending. They were also able to establish a second branch in Durban, Natal. The treasurer reported that BTNA received contributions from the nurses working at the mines (e.g. Crown Mines, City Deep and Modder Bee) as well as from hospital nurses (University of Witwatersrand 1934b:1).

The BTNA aims contained no reference to research or involvement in policy development (neither did the initial SATNA aims; this was added later). The BTNA aims also did not consider matters related to services and practice, and neither was the socio-economic welfare of Black nurses mentioned. Such omissions were unfortunate if one considers the working conditions of nurses in mission hospitals and the rural areas.

The 1939 annual report from the Charles Johnson Memorial Hospital stated that the living quarters of the Black nurses required urgent attention. The work of the nurses was then described. Sister-in-Charge, Miss Alice Doble, S.R.N. (State Registered Nurse) and S.C.M. (State Registered Midwife) took charge of the hospital. She had the responsibilities of patient care, training and supervising trainees as well as supervising the district nurses (University of Witwatersrand 1939a:27-28). In rural areas, the so-called native district nurses functioned mostly independently, with little medical support (Gelfand 1984:21). One district surgeon’s report stated that the Hlazakazi community accepted the presence of the District Nurse Lena Bhengu very well and that he (the doctor) visited her only twice a month (University of Witwatersrand 1939a:24). The scarcity of medical practitioners and the travel distances involved was also confirmed by the Sister-in-Charge of the Holy Rood Hospital at Endhlozana. Miss Kendrick (SRN; SCM) stated that they

received a monthly visit from the district surgeon, but that he was always available to advise nurses by telephone (University of Witwatersrand 1939b:44). Although they were not formally stated in its aims, the BTNA did address such matters, for example in the 1934 and 1942 resolutions communicated to the SATNA. In them, they requested assistance with their members' conditions of employment and practice (DENOSA 1942a:5).

5.4.3 BTNA, SATNA and the SAIRR

Prior to 25 November 1932, any discussion about Black nurses and their professional future in South Africa was conducted without *direct* representation. The SAIRR conference held in July 1932, where decisions were made about Black health services and nurse training, had no Black or Coloured nurse representatives present. The conference records cited Miss BG Alexander and Mrs WG Bennie (not LL) as attending representatives of SATNA. Mrs Bennie (and Dr HA Moffat) had the additional task of being the representative(s) for the Cape Peninsula Joint Council of Europeans and Bantu. The first resolution of the conference (moved by Miss Alexander and seconded by Mrs Bennie), namely that hospitals able to provide training for state registration by Black and Coloured nurses should do so immediately, was passed (Marks 1994:95-97; University of Witwatersrand 1932). BTNA was established four months after the SAIRR conference.

Thus, after 1932, BTNA was represented at professional gatherings, but not by Black nurses. Rather, after receiving proposals from the BTNA branches, SATNA members or missionaries spoke on behalf of BTNA at professional meetings. This was illustrated in the report of the BTNA President, presented on 9 December 1934 at the second annual meeting of the association. The President, Nurse Caroline Zondi, confirmed that Miss Ruth Cowles represented BTNA at the conference of the SATNA Central Governing Board and that the resolutions sent to the conference had been "most sympathetically received and supported" (University of Witwatersrand 1934a). Resolutions included BTNA's call to improve the training conditions and facilities for Black nurses. Furthermore, BTNA "urged that steps be taken by Government towards the organisation of a nursing service amongst Bantu people in rural areas" (DENOSA 1934:9).

An early example of BTNA advocating on matters related to professional education can be found in the minutes of the SATNA Central Board meeting held on 18 June 1934.

BTNA's proposals about the training of Black nurses resulted in the following resolutions (DENOSA 1934:6; SATNA 1934c:328; University of Witwatersrand 1934c):

- The Minister of Public Health was urged to make the full training of Black nurses compulsory.
- Hospitals equipped to train Black nurses should provide full training that would enable probationers to write the Medical Council examination.
- Probationers at mine hospitals should be given an opportunity to work in other hospitals so that they could gain experience in nursing women and children.
- The government was urged to commence with a subsidised, trained nursing service for Black people in rural areas, using trained nurses already available – not waiting for medical aids to be trained.

Since the early 1930s, the SAIRR had played a key role as spokesman on behalf of BTNA. Correspondence between SATNA members (Miss BG Alexander, Mrs LL Bennie and Miss R Cowles) and the SAIRR (Mr Rheinallt Jones) illustrates that the training of Black nurses was also discussed in that forum (University Witwatersrand 1934c). Miss Cowles, the BTNA representative on the fourteenth SATNA Board (1934–1936) (Searle 1982a:97), communicated the SATNA resolutions in a letter (dated 23 August 1934) to Mr Rheinallt Jones of the SAIRR. Although Miss Cowles felt that not enough time was spent in discussing the training of Black nurses, she was optimistic about the fact that “many of the nursing profession in South Africa ... were friendly towards the Bantu nurses, and champions of the cause of raising the standard of their nursing education” (University of Witwatersrand 1934c). This letter illustrated that although the liberal-minded nurses were in charge, even they did not openly challenge social norms. A White SATNA member spoke on behalf of BTNA.

The affiliation between BTNA and SATNA was not only by means of representatives and in the form of correspondence. Members also had direct contact. When BTNA held its second annual meeting on 9 December 1934, among those attending were BTNA members, Mrs and Miss Bridgman (missionaries), Dr AB Xuma, medical doctor, and from 1940 the President General of the ANC (Welsh 2000:422), Dr Chapman (medical doctor), Mr. Rheinallt Jones (SAIRR representative) and SATNA representatives. Mrs HC Horwood, the SATNA Organising Secretary, gave a speech about the high moral values and professional loyalty required from all nurses (an appropriate topic for a speech

considering that the BTNA badge had the word *Loyalty* inscribed on it). Finally, to celebrate the association's second birthday, there were blue and white flowers (the colours of BTNA were blue and silver) and an iced cake with two white candles. Miss Winter lit the candles and so a "delightful social hour" passed (University of Witwatersrand 1934a). Miss Winter became the 1936–1938 BTNA representative on the fifteenth SATNA Board (Searle 1982a:97).

5.5 DEDUCED FROM THE DATA: VULNERABLE INSIGHTS

SATNA and BTNA were the first South African nursing associations to succeed in forming professional collectives which were recognised by society and the medical fraternity as the voices of the profession. The *South African Nursing Record* (VAD Probationers ... 1917:62) recognised that united action was powerful: "The essential thing is to have a united body which is watching for such anomalies [e.g. VAD training] and can draw the attention of the proper authorities to them". SATNA and BTNA made it possible for South African nurses to participate (though in a limited way) in the decisions being taken by the Medical Councils about their professional practice and work conditions. SATNA especially was effective, as its continued campaigning (from 1914, when it was established) resulted in it having two nurse representatives (in 1928) on the new Medical Council. Gradually the nursing profession through the professional organisations became an active participant (not a bystander) in its professional affairs.

SATNA and BTNA published nursing journals, which gave nurses a means of communication and kept them informed about professional matters (the researcher was unfortunately unable to find any archived BTNA journals). By means of ICN membership, South African nurses could converse on an international platform about professional developments in nursing. The *South African Nursing Record's* and later the *South African Nursing Journal's* scientific articles informed and communicated internationally accepted standards of nursing care, while the editorial discussions conveyed SATNA's notions of professionalism to its readers. In this way the association influenced South African nursing's emerging professional image.

Both BTNA and SATNA aimed to improve the standards of nursing education, which in turn had a positive influence on nurses' socio-economic status and professional image. BTNA aimed to create an education fund which would assist nurses in their studies, but

no evidence could be found to confirm that they did. What could be confirmed from the data was that both associations campaigned for nurses having better work hours and leave privileges. BTNA managed that by making resolutions to their affiliate, SATNA. SATNA succeeded in negotiating the 1918 Relief Ordinance and establishing social assistance funds (e.g. the Nurses' War Memorial Fund) for nurses.

SATNA's endeavour to improve the standards of nursing education and the resultant high standard of nursing care positively influenced the image of the nursing profession. Furthermore, by calling for legislation that would prevent untrained and unregistered nurses from practising, SATNA ensured the safety of the public. Trained, registered nurses and midwives would render better health care. The standards of training required by the association did, however, contribute to the shortage of South African trained nurses and drove the need to make use of overseas trained nurses. Too few local candidates had the required educational background, and few training centres could provide the registered nurse training programme. Despite the shortage of educated candidates, SATNA did not lobby for a better school system that would have enabled more candidates to enter the formal nurse training system. The nursing shortage was especially apparent in rural South Africa, and it was for this reason that BTNA called for the urgent establishment of health services there.

SATNA also called for legislation that would direct nursing practice, as it felt that it would only be fair if all practising nurses were subject to the same disciplinary measures. The 1891 voluntary state registration system implied that registered nurses were subject to discipline by the Medical Council(s), while the unregistered nurses and untrained were not. In fact, they could continue to work as nurses as there was no legislation to outlaw such practice. For these reasons, SATNA called for legislation that allowed only trained, registered nurses to wear a specific distinguishing uniform, which would illustrate the nurse's level of training and competence to the public. To this day, South African nurses wear distinguishing devices which denotes their qualification status.

Where the two associations diverged was in their membership. While BTNA invited all nurses (registered and hospital certified) to become members, SATNA believed in creating a professionally exclusive group that consisted of registered nurses only. SATNA's elitist membership policy contributed to the nursing profession's attaining a desired professional image, but it also sowed the seeds of discord, as a group such as

the Black and Coloured nurses had to establish their own professional organisation. SATNA's elitist stance prevented it from bringing all registered nurses into the fold.

Although SATNA and BTNA were affiliated, the extent of their co-operation was constrained by early 20th-century South Africa's Western-style social class system. This class system relegated Black people to the lower social classes due to their perceived poor education and socio-economic position (and from the 1930s this would be expressed in legislation). This was nowhere more evident than in the fact that BTNA was represented at formal meetings and conferences by a member of SATNA or by missionaries. Early in the 20th century, there were also very few Black registered nurses (in 1922 there were three), which would have further limited the extent of their influence on professional matters.

Referring to the development of the nursing profession, Searle (1987a:116) argued: "Being manifestations of social evolution and organisation, all issues have an ongoing evolutionary thrust and are bedevilled by the constraints of the era". This chapter illustrates that the emerging nursing profession was intimately connected with a changing society: nurses as women strove for economic and professional independence, but were confined by a male (medical) dominant society and compelled to function within its constraints.

During the early years of the South African nursing profession's development, SATNA was the dominant voice that demanded an organised system of nurse training, the protection of nurses and midwives by means of compulsory state registration (recognition) and a midwives' board (What we want 1916:273-274). Figure 5.6 provides a historical timeline that illustrates the significant events that occurred in South Africa, the world at large, and its influence on the development of South Africa's professional nursing organisations.

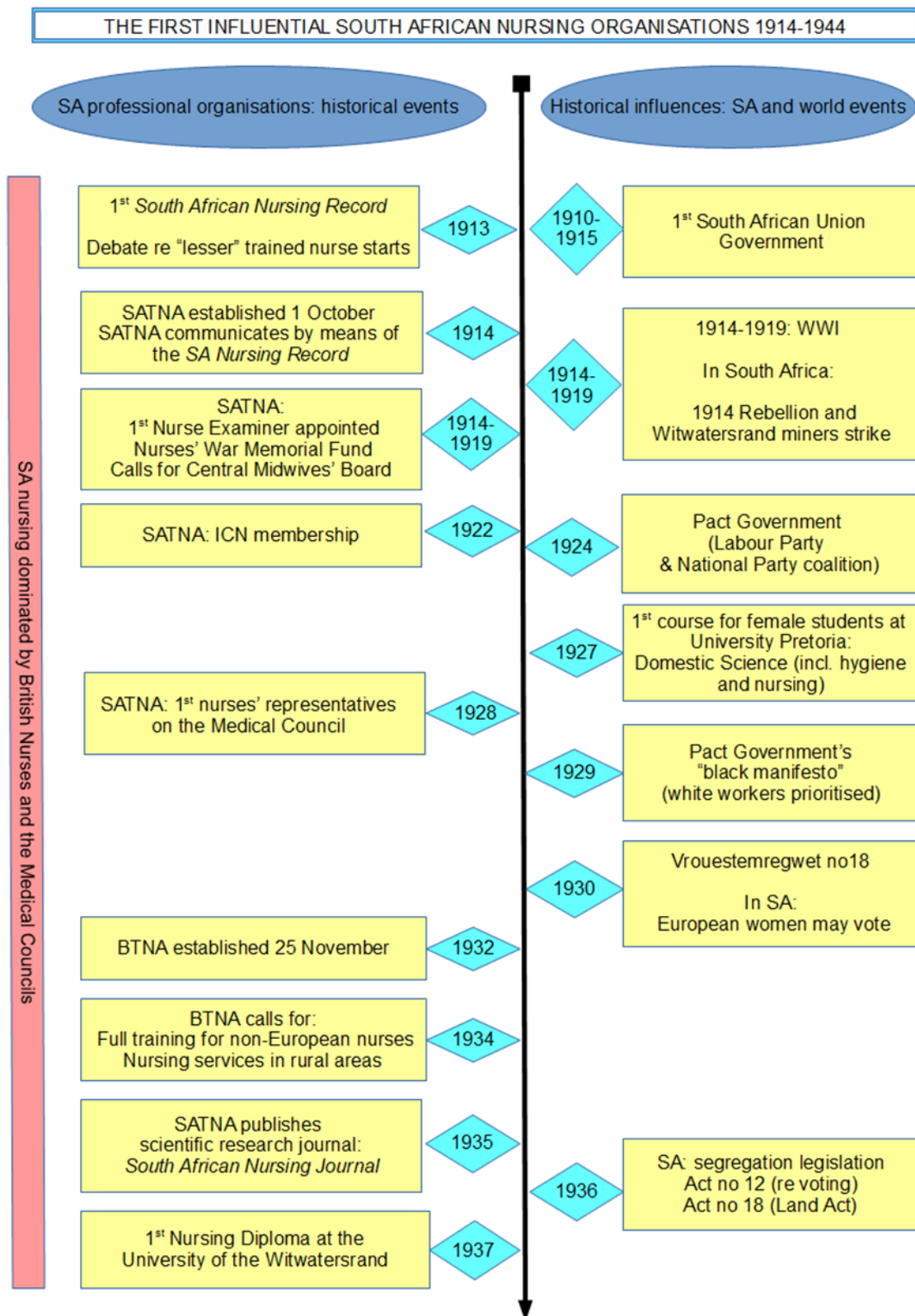


Figure 5.6 The influence of the first South African nursing organisations in a historical context

5.6 SUMMARY

This chapter illustrated the influence of the first two significant nursing organisations on the development of the nursing profession. SATNA and BTNA addressed matters (such as working conditions) that concerned the profession. By advocating for better educational standards of nursing training they succeeded in improving the status and image of the profession. Ironically, the demand for educated nurses limited the number of registered nurses in South Africa because few nursing candidates could comply with the entry requirements. Chronological considerations arguably require discussion of the 1942 trade union crisis in this chapter, but in the interests of providing clear historical context, the 1942 events and the subsequent establishment of SANA in 1944, will be discussed in Chapter 6.

CHAPTER 6

THE 1942 TRADE UNION CRISIS AND THE PROFESSIONAL NATURE OF SOUTH AFRICAN NURSING

6.1 INTRODUCTION

Chapter 5 described the causal mechanisms that led to the establishment of the first influential South African nursing organisations and how those organisations influenced the development of the nursing profession.

In this chapter, the narrative describes how over time the diminishing British colonial influence and the general state of South African society post-World War II altered the balance of power in the country's nursing profession. Events during the 1942-1944 trade union crisis, the factors that created the crisis and the outcome thereof are described. The trade union crisis resulted in SATNA, a nursing association with voluntary membership transforming into SANA, a nursing association with compulsory membership prescribed in law.

6.2 SOCIETY, POLITICS AND TRADE UNIONISM

In South Africa, WWII (1939–1945) brought specific political, socio-economic and health-related matters to the fore. Shortly after the start of WWII, the British Colonial Office established the Colonial Nursing Service (CNS) in 1940. This enabled British nurses to take the lead in nursing training and practices throughout the British Empire. Thus, during the years of war, British nurses dominated the profession. Solano (2007:150-151) believed that nurses acted more as “agent[s] of imperialism” rather than as “cultural conduit[s]”. The CNS ensured that White female nurses remained at the top of the nursing hierarchy in the colonies, thus controlling indigenous nurses. Gradually, as British colonies gained independence, this position changed, and the locally trained nurses gained control (Rafferty & Solano 2007:147-148, 150-151). The first hint of such power dynamics in South African nursing became evident during the 1940–1942 trade union crisis.

6.2.1 The South African social and political landscape after WWII

Social dynamics were changing and Britain's influence in the country was lessening. Afrikaners rose to a position of political dominance, while Black, Coloured and Indian people resisted the resultant socio-political and economic effects on their lives. Trade unionism in South Africa was affected by political change. This atmosphere would greatly influence the country's nursing profession in the 1940s.

Despite industrial growth in the South African economy during and after WWII, the cost of living escalated, while workers' salaries did not. This led to numerous strikes in the country (Another 'black peril' 1989:56; Walker 2001:484-485). A severe drought during 1941–1943 further caused job losses and impoverished rural areas. These socio-economic conditions resulted in food shortages and triggered rapid urbanisation in the 1940s and 1950s. The urban Black population, for example, increased from 1,7 million people in 1946 to 2,5 million in 1951. Urban overcrowding and poor living conditions led to the ill-health of the people. The provision of proper housing (by 1951 there was a shortage of approximately 250 000 houses), sanitation and health services did not occur quickly enough to keep up with the growing demand. Conditions such as malnutrition, typhus, tuberculosis and other respiratory diseases increased. The crisis in the health care sector, evident since the 1930s, manifested itself during the WWII years in the country's inability to provide care to many South Africans (Esterhuizen 2012:83-84; Mager & Mulaudzi 2011:370; Walker 2001:484-485).

The 1944 South African National Health Services Commission Report, also referred to as the Gluckman Report (the commission started its work in 1942; the report was named after the chairman of the commission, Henry Gluckman), investigated the country's health-care system and inter alia found that the hospital bed availability was better for White people (1:304) than for Black people (1:1 198). Similarly, medical doctors were significantly more available for White people (1:308) than for Black people (e.g. 1:30 000 for persons in the then Northern Transvaal Reserve) (Van Rensburg & Benatar 1993:104, 107). The Gluckman Report suggested that an integrated health service should be established, with a focus on social medicine. The National Party government chose not to follow this suggestion after 1948. Gradually, the Department of Health established a system of health centres and clinics in the "homelands", which were established by legislation such as the Bantu Authority Act (68 of 1951) (South African History Online

2017). These clinics, staffed by nurses and supported by lay health-care workers, were required to provide holistic health care to their communities and would continue to function until the mid-1980s (Digby 2012:830). Also involved in the health care of rural communities were missionaries, who had established many clinics and small hospitals up to the 1940s. Some of the larger mission hospitals started to train nurses, so that proper health care could be provided to communities. Advances in science such as antibiotics, intravenous fluid therapy and new surgical techniques during WWII gave greater responsibilities to nurses, and standards of hospital practice were raised through the establishment of a school of nursing (Gelfand 1984:23, 69-70).

In South Africa, after years of colonial (British) control, Afrikaner people started to gain the political upper hand in the 1940s. Only White persons had the right to vote, and with 60% of voters being Afrikaners (in comparison with 40% English-speaking voters) the political landscape changed. The majority of Afrikaners, in their opposition to British control, supported the National Party's post-WWII policy of apartheid because they believed that their socio-cultural interests would be protected. The rising spirit of Afrikaner nationalism reached its peak in the 1950s to 1970s in the form of the apartheid system (Liebenberg 1980:480-481). A series of apartheid laws created a society in which racial segregation was strictly enforced and the movement of people regulated. Specific jobs were reserved for White workers (Scher 1993:355-357; Towards another ... 1989:86).

6.2.2 Trade unionism: The Garment Workers' Union

The socio-economic conditions created by WWII and South Africa's post-war political landscape encouraged the development of trade unions, with many strikes occurring in the industrial sector of the economy (Grundlingh 1993:310-312; Roots of militancy 1989:71-72). The government's segregationist policies were evident in the early post-WWI period, when Black workers were not allowed to join White, Indian or Coloured trade unions (Brits 1993:166; Mager & Mulaudzi 2011:376-377).

Larger numbers of White women, most of them Afrikaners, entered the workplace during the 1920s and 1930s. They worked as semi-skilled labourers in the laundry, confectionary, furniture and clothing industries. During this time, with assistance from the Communist Party, the multiracial Garment Workers' Union was established under the leadership of Solly Sachs. The aim was to organise female workers in the clothing

industry. Many Afrikaner women were members of this trade union (Brits 1993:194-195; Grundlingh 1993:269; Liebenberg 1980:503), and Sachs was instrumental in helping to establish the foundations of future trade union activities by female workers (Brits 1993: 194). The Garment Workers' Union played a key role in providing SATNA with its first organised labour challenge: the so-called 1942 trade union crisis.

6.3 THE TRADE UNION CRISIS (1942–1944)

The 1942 trade union crisis was essentially a struggle for power between SATNA and trade unionists in South African nursing. The rivalry ended in 1944 with the establishment of the profession's independent regulating body, SANC, and a compulsory professional organisation, SANA. An in-depth discussion of the 1942 trade union crisis is essential, because the outcome established the foundation that would direct South African nurses' professional development for 52 years.

6.3.1 Professional status and nursing activities before 1942

The South African Medical, Dental and Pharmacy Act (13 of 1928) established an integrated South African Medical Council (SAMC) (instead of four provincial Medical Councils) and made provision for the inclusion of two nurse representatives (HPCSA 2016; Marks 1994:121; University of Witwatersrand 1934d). Although it was the first time that South African nurses were represented on a Medical Council, the two nurse representatives were only allowed participation in the Nursing Committee of the Medical Council (Marks 1994:121-122), which generally was last on the agenda and, according to Miss Alexander, "was usually rushed through" (SATNA 1934c:336). Mrs Bennie declared "that after five years she had a feeling of utter futility", and that she voted against the SAMC resolution that stated that the SATNA resolutions were given due consideration (SATNA 1934c:336). In matters of training, which SATNA considered one of its priorities, the nurse representatives "were outvoted every time". The collective voice of nurses remained that of a restricted minority (Searle 1982a:41). That insignificant position was evident when the Union government established the National Health Services Commission in 1942 to review the South African Union's health-care system, without inviting a single nurse representative to join it. It was only after an outcry (and in part due to the 1942 trade union crisis) that Miss BG Alexander was co-opted onto the committee (Marks 1994:123-124; Union Health Commission 1942).

As early as 1934, the SATNA Central Governing Board voiced its displeasure at such limited representation and position of power within the SAMDC. A call for an independent General Nursing Council – or alternatively, greater representation on the Nursing Committee and on SAMDC itself – was made. Some of the SATNA Board members felt that the drive to establish an independent nursing council would take less time than it did to get representatives on the SAMC: “women now had the vote and, if the Association gets the backing of the women themselves, things ought to move much quicker than in the past” (SATNA 1934c:336). The SAMDC and the Secretary of Public Health opposed the idea. SATNA then held a nurses’ referendum, which indicated that an increased nurse representation on the Medical Council was preferred. The referendum did not sway the opinion of those in power (Marks 1994:122, 124-125). A factor that might have contributed to the Medical Council’s resistance was that SATNA did not represent the majority of South African nurses. Searle (1982a:41) states that only approximately 30% of South African registered nurses and midwives were SATNA members during WWII (1939-1945).

Despite this setback, SATNA steamed ahead with the planning of its 1939 Silver Jubilee celebrations. The celebrations would have included various activities such as a dual-language (English and Afrikaans) church service aimed at achieving unity among South African nurses. Student nurses, though not eligible to be members, were also invited to attend the congress “if they wish” (DENOSA 1939:1). Unfortunately, the Silver Jubilee celebrations had to be cancelled due to the outbreak of WWII (Nursing Echoes 1939:256). Instead of celebrating their first 25 years of being a professional nursing association, SATNA redirected its activities towards the war effort, such as donating three ambulances to Defence Headquarters and £5000 to the Civilian Nurses’ Air Raid Victims (Message from Lady Duncan 1942:1). Using a historical inflation rate calculator (Morley [Sa]) and the current (28 October 2016) exchange rate for the South African rand and the British pound it was calculated that £5000 would have been worth in 2016 ZAR 3 848 450.

In April 1942, a unanimous SATNA resolution was sent to the NCW. In it, SATNA expressed its concern about the unacceptable state of health services for Black people in South Africa. SATNA requested the NCW to cooperate in “bringing pressure on the Government” to implement measures that would alleviate the situation before the end of the war (Marks 1994:132-133). This is in line with the SATNA President’s speech at the

1942 biennial conference, where she called on the association to “bestir itself and to indicate in no uncertain way its opinion about the betterment of conditions” (Trained Nurses’ Conference 1942). At that same conference, the SATNA Board resolved to investigate the requests of BTNA related to the permanent employment of its members and the required year of post-graduate supervision. At the behest of BTNA, SATNA also wrote to the Department of Health to ask for the establishment of a Department of Nursing that would manage the supervision of Black District nurses (note sub-section 5.4.2.2).

The WWII years would demand more from the professional association than only efforts to increase representation on the SAMDC, investigate the conditions of service of their associate (BTNA) members, advocate for the health of society and make financial contributions to the war effort. War-time conditions would contribute to SATNA experiencing its first major opposition to its objective of establishing a unified trained South African nursing force.

6.3.2 The trade union crisis unfolds

In August 1942, SATNA held its eighteenth biennial conference and the meeting of the Central Governing Board in Klerksdorp, Transvaal (the modern North West province). In her letter read to the 300 attendees at the conference, the SATNA patroness, Lady Duncan, commented on the influence of WWII on nursing services in South Africa and the nurses’ contribution to the war effort (Her Excellency praises ... 1942). Plans to improve the post-war health care system (for patients and nurses), amendments to the SATNA constitution, nurse training and the question of compulsory nursing registration dominated discussions at the conference (Nurses discuss ... 1942:5). Despite its relatively small representational standing, SATNA was considered the leader in all professional nursing matters.

6.3.2.1 SATNA “in touch” and “in control”

Opening the eighteenth biennial meeting of the SATNA Central Governing Board in August 1942, Miss BG Alexander summarised SATNA’s activities in her presidential address. She referred to the achievement of having representation on the SAMDC Nursing Committee and the advantages of affiliation with the ICN (i.e. contact with standing ICN committees and access to scholarships). Efforts were being made to

improve and standardise nurses' salaries and pensions "which, it was felt, would lead to greater contentment among nurses" (Trained Nurses' Conference 1942:1). Furthermore, proposed amendments to training regulations were being finalised and Mrs SM Cribb (Honorary Organiser of the student nurses' section) was recognised for her efforts in this regard. Miss Alexander urged matrons and sister tutors to stress the importance of SATNA membership to students. Also mentioned were those nurses engaged in the war effort and the negative influence that this had on the number of nursing staff available to work in South African hospitals. Miss Alexander stated that the purpose of the conference was to contribute to the betterment of health services and to make the public aware of the professional difficulties that nurses had.

Adding an Afrikaans portion to a speech for the first time (and underlining syllables that should be accentuated), she concluded by stating: "In 'n tyd van soveel onrus en misverstand, is dit 'n voorreg om 'n lid te wees van 'n professie wat net een strewe het – naamlik die mensdom te dien, en wat, in die vervulling van sy ideaal geen onderskeid erken tussen ras, kleur of geloof nie" (Trained Nurses' Conference 1942:1). (In this time of unrest and misunderstanding it is a privilege to be a member of a profession that has only one aspiration, namely to serve humankind, and that in its effort to fulfil that ideal does not acknowledge differentiation of race, colour or religion). The inclusion of Afrikaans in the speech illustrated society's new expectation that South African leaders, and especially its politicians, should be fluent in that language (Welsh 2000:415). In his welcoming speech, the representative of the Klerksdorp Hospital Board stated that SATNA was recognised for its ethical practice and that the public accepted SATNA's protection of patients and nurses (Trained Nurses' Conference 1942:1).

By the end of the Klerksdorp conference several resolutions were made which were in line with the issues raised by Miss Alexander in her welcoming speech. The conference chose a committee that would draft recommendations for reform in South Africa's social services and then turned its attention to the matter of professional status. Points 36 and 37 of the SATNA Board's minutes of meeting (11–12 August 1942) address the compulsory registration of nurses and the wearing of distinguishing devices. These measures were regarded as the only effective means of recognising and protecting professionally trained nurses, midwives and "mental nurses" (DENOSA 1942a:12). The Board was adamant that it was time to implement such measures of control. Point 51 of

the minutes of meeting stated (DENOSA 1942a:16): “It was agreed that, if the SA Medical Council refuses to move in this matter, it be taken to the Government”.

Nursing training also received due attention. It was agreed that nurses’ basic training had to be more comprehensive in nature and that candidates should have a Matric (Grade 12) certificate (thus confirming the educated, professional nature of nursing). It was recommended that the training of male nurses be resumed. Furthermore, it was stated that the proposed changes in training should protect student nurses and midwives “who are as a whole being regarded as cheap labour” (Nurses discuss ... 1942:5). Miss Alexander urged speedy action, as there were provincial councils who were also considering changes in nurse training. It was essential that SATNA make recommendations to the SAMDC first. At their meeting, the SATNA Board initially accepted a resolution that every trained nurse who received his or her SA Medical Council certificate automatically become a member of the association. Reconsidering the feasibility of such resolution, it was realised that there was no “machinery whereby it can be enforced” (DENOSA 1942a:7-8) and thus the motion was withdrawn.

6.3.2.2 Student and trained nurses protest

SATNA’s resolution to formally communicate with its controlling professional body (the SAMDC) about nursing training did not satisfy all nurses. Shortly after the Klerksdorp conference, a group of students and sympathetic junior nurses from the General Hospital in Johannesburg approached the South African Trade Union Propaganda Organising Committee with the purpose of establishing a nurses’ trade union. This committee formed part of the South African Trades and Labour Council and had the task of “organising unorganised workers” (Marks 1994:126). The first meeting between the trade unionists (the main speaker was a gentleman from the Garment Workers’ Union) and approximately 250 nurses (Searle 1965:249) was held on Sunday, 30 August 1942, where “some rather ill-advised remarks” from the audience caused “a cleavage of interests between the ranks of the trained and untrained nurses” (DENOSA 1942b:1). Nonetheless, the chairperson of the meeting (a Labour party member) confirmed that a union would be formed and stated that the constitution and the election of office bearers would be finalised at the next meeting. No resolutions were passed (DENOSA 1942b:1; Searle 1965:248-249).

On Sunday, 6 September 1942, a second, apparently poorly publicised meeting was held at Red Cross House. In her summary of events, Jane McLarty, first Vice-President of the SATNA Witwatersrand Branch and chairperson of the special meeting held to discuss the trade union issue, stated that there was a feeling that the unionists were trying to keep the meeting “rather quiet” (DENOSA 1942b:1). Still, about 400 nurses attended the meeting (Searle 1972:249). It seems as if the trade unionists wanted to limit any opposition to their plans, as no general discussion was allowed at the second meeting and comments were limited to those who had signed membership application forms. Remarks were made from the audience that the membership application forms did not allude to a “proposed” union and that no detail was asked about the applicant’s qualification status and years of nursing experience (DENOSA 1942b:1).

The Chairperson, Mrs Jessie McPherson, started with the first point on the agenda: adopting a constitution. A 10-page document was read and explained, whereupon a student nurse asked a question which was ruled as being “most irregular” (DENOSA 1942b:1) by the chairperson. The student and the audience insisted that the question be answered and in doing so, the outcome of this second trade union meeting (and South African nursing history) was altered. The student asked what the position of a minority of non-union nurses would be in a large institution. The chairperson of the union meeting replied that “it would be the duty of the majority *to force* the minority to join the Union” (DENOSA 1942b:1). The minutes of the meeting indicated that the “word ‘force’ was later amended to ‘persuade’” (DENOSA 1942b:2). The protesting audience subsequently voted that a general discussion should be allowed to take place. The potentially significant meeting ended with no adopted union constitution and no office bearers selected. Only a committee of four trained and two student nurses was chosen to discuss matters further with the organisers (DENOSA 1942b:2; Searle 1972:249-250). It should be noted that most of this union committee’s members were trained nurses, which is ironic if one considers that that was one of the students’ grievances: that the exclusive trained nurses did not consider their needs.

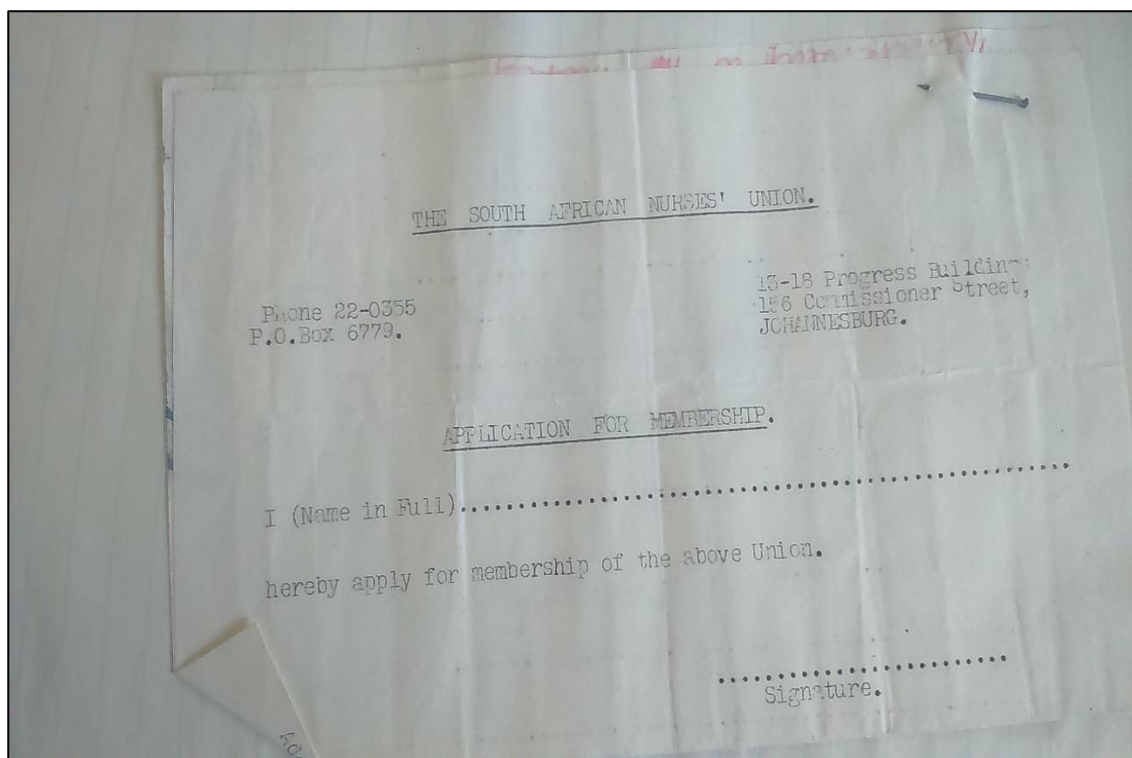


Figure 6.1 The 1942 application form for membership of a nurses' trade union
(DENOSA [Sa]a)

6.3.2.3 SATNA reacts to the threat of trade unionism

At this point, the SATNA Witwatersrand branch organised a special meeting, open to all nurses, to discuss the proposed nurses' trade union. Approximately 300 SATNA members and non-members attended the three-hour meeting on 11 September 1942, which was chaired by Jane McLarty. Also present was a representative of the NCW, Mrs. Mitchell Hunter (DENOSA 1942b:1; Searle 1972:250). After sharing accounts received from those who had attended the two union meetings, Miss McLarty explained the factors that would influence nurses who joined a trade union (DENOSA 1942b:2):

- The title of nurse was not used to only refer to trained persons, but indiscriminately (note the statement made by an audience member on 6 September 1942 about the application form not asking details about a nurse's qualifications or professional status).
- Due to nurses working in various health care settings, the application of the Industrial Coalition Act (36 of 1937) to all nurses was doubtful.

- The position of student nurses under the Industrial Coalition Act (36 of 1937) was not clear. Although SATNA had obtained legal advice on the matter, no conclusive answer was received.
- Nurses had to consider their position in relation to industrial strike action. Firstly, it was considered unethical behaviour on the part of the nurse. Secondly, nursing services themselves might be declared an essential service, thus rendering strike action by nurses unlawful.

Miss McLarty admitted that SATNA at that time did not represent all nurses. She accepted that the association must reorganise itself either into a trade union or obtain a charter. Her willingness to reorganise SATNA was possibly influenced by the resolution taken at the Klerksdorp conference a month earlier to adapt the constitution of the association (the SATNA constitution had to be adapted to clarify the roles of the shareholders and its Executive Committee). She appealed to nurses to consider the benefits that a strong professional association could offer and then specified the fundamental priority, namely that SATNA membership numbers must be increased. The NCW representative assured nurses of their 40 000 members' support and stated that some form of union should emerge from SATNA – one that would enable student nurses to participate in nursing affairs (DENOSA 1942a:7; DENOSA 1942b:2-4).

Reason won the day, and in contrast to the two trade union meetings, the SATNA special general meeting made nine resolutions which, with a few attendees abstaining, were passed unanimously. The meeting expressed its confidence in SATNA's ability to manage the required changes. It was agreed that an emergency meeting of all SATNA branches was to be held in Johannesburg as soon as possible to discuss the situation. At this meeting, the students would be represented. A copy of the special general meeting's minutes and resolutions would be sent to all training schools to inform them of the adopted resolutions. In the meantime, SATNA would consult with the Registrar of Trade Unions to discuss the challenges of registering the association as a trade union. Members of a university (it is unclear which), the Law Society, the Chartered Accountants Society and the Trades Union Council would form part of an impartial group selected to advise the SATNA on the drafting of a new constitution. Finally, a sub-committee consisting of SATNA members and the union committee members (those selected on 6 September) was chosen to meet and engage in continued discussions (DENOSA 1942b:2-4).

During one such discussion between SATNA and the trade unionists, it emerged that nursing students felt particularly aggrieved about working conditions, salaries and training conditions. Due to WWII, there was a shortage of trained nurses in South African hospitals, thus leaving an undesirable trained vs. untrained nurse staff ratio. The burden of care became that of the untrained (student) nurse (note sub-section 6.4.2.1 of this chapter). These conditions made it impossible to carry out clinical accompaniment at the bedside. It also created difficulty for students who were expected to attend lectures in off-duty time. Furthermore, military nurses received a higher salary than civilian nurses. The SATNA Executive Committee met on 11–12 October 1942 and stated that urgent action was required. On 15 October 1942, the SATNA Central Board met with the Witwatersrand Branch to plan a campaign strategy for the required reorganising of the association. (DENOSA 1942d:1; DENOSA 1942e:1; Marks 1994:113; Searle 1982a:41).

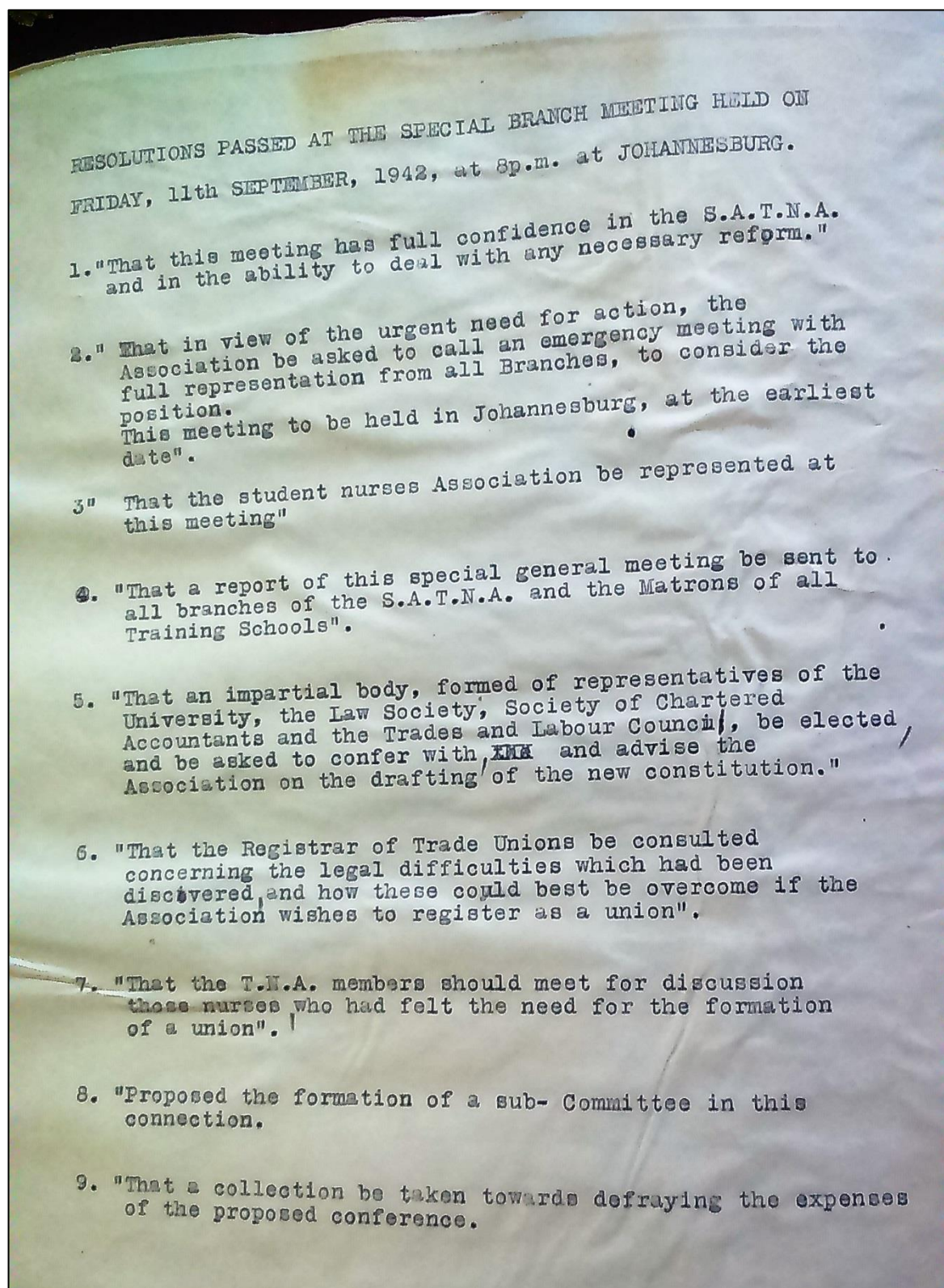


Figure 6.2 The resolutions taken at the special SATNA Witwatersrand Branch meeting held on 11 September 1942 to discuss the trade union crisis. The page is pasted in the branch's minutes of meeting book, along with the complete minutes of the meeting.

(DENOSA 1942c)

6.3.2.4 *Reorganise or suffer an eclipse*

Searle (1982a:42) states that nurses in South Africa reacted strongly, with some being against and others having a pro-unionist stance. It became evident that the trade union issue had the potential to divide rather than unify the profession. On 15 October 1942, the SATNA Central Board met with its Witwatersrand Branch to discuss a campaign strategy to ward off the nurses' trade union threat. Mrs SM Cribb, the SATNA Organising Secretary and Honorary Organiser of the student nurses' section (Trained Nurses' ... 1942:1), stated: "It was for the nurses of South Africa to decide what form their organisation should take, and if they fail to seize the opportunity of gaining control of their profession, nursing in S. Africa [sic] must suffer an eclipse" (DENOSA 1942e:1).

To inform nurses of how SATNA (at that time registered under the Companies Act) could be transformed, a comprehensive campaign was planned, which included a bilingual memorandum, branch meetings with Mrs Cribb attending (she was specifically tasked with this responsibility by the SATNA Executive Board), a national conference, press articles and even "a talk on the wireless" (DENOSA 1942e:1; Du Preez & Brannigan 1991:38; Status of Nurses [Sa]; Searle 1972:250-251).

There were two options on the table: to register as a trade union under the Industrial Conciliation Act (36 of 1937) or to attain an Act of Parliament which would give the nurses of South Africa independent control of their profession. A trade union would assist nurses about their conditions of employment and socio-economic welfare but would exclude certain groups (e.g. nurses working in the government sector, student nurses and Black nurses) and affect SATNA's membership of the ICN. On the other hand, an Act of Parliament would be an expensive endeavour because a Private Members Bill, costing about £500 (ZAR 384 845 in 2016) would have to be introduced. Such a bill might be passed in one parliamentary sitting, but it could take up to eight years to achieve. Furthermore, to even apply for registration by means of an Act of Parliament, SATNA needed a 50% majority vote from nurses. The trade union crisis created a sense of urgency amongst the SATNA leadership, but the association needed time to inform all nurses and obtain their support for the proposed changes. Delaying tactics were therefore implemented: the SATNA Executive Committee requested assurance from the Registrar of Trade Unions and the Minister of Labour that no trade union for nurses would be

registered before SATNA decided on its new organisational structure (DENOSA 1942f; DENOSA 1942e:1-2).

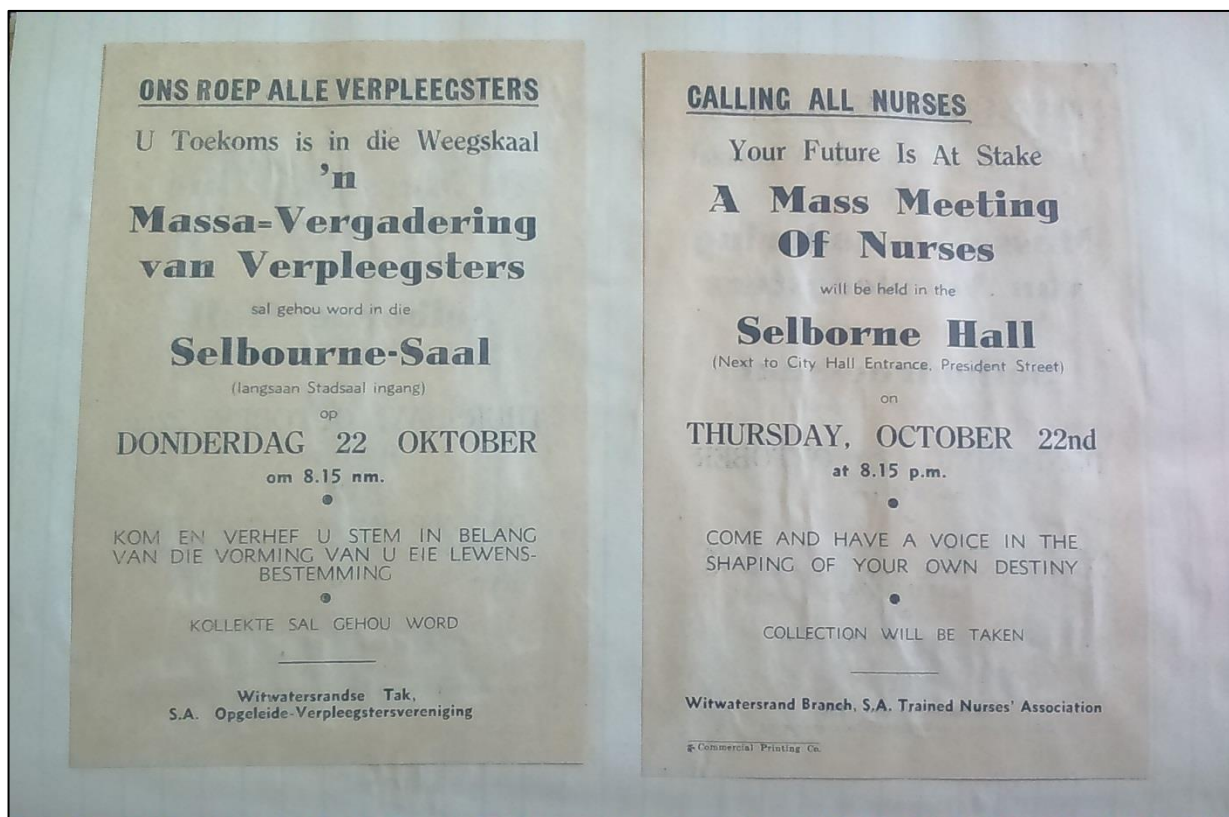


Figure 6.3 Pamphlets calling nurses to a meeting during the 1942 trade union crisis
(DENOSA [Sa]b)

Memorandum from the Executive Committee of the S.A. Trained Nurses' Association to the Nurses of South Africa

The Executive Committee having held a special meeting to consider the best means of securing a sound legal basis for the future organisation of nurses in South Africa, now wishes to place before the nurses of the Country an unbiassed statement of fact as to the relative advantages and disadvantages of the two possible solutions. They are:—

(a) Registration as a Trade Union under the Industrial Conciliation Act No. 36 of 1937

or

(b) A special Act of Parliament providing for control by nurses of all matters concerning the profession.

It is quite evident that the present registration of the Association under the Companies Act is unsuitable and our legal advice makes it doubtful whether such registration can be maintained.

TRADE UNION.

REGISTRATION UNDER THE INDUSTRIAL CONCILIATION ACT NO. 36, OF 1937.

Advantages

1. It provides the recognised machinery for:
 - (a) the regulation of conditions of employment by agreement and arbitration.
 - (b) the prevention and settlement of disputes between employees and employers.
2. It would appear that owing to the wide scope of the Act a constitution applicable to the nursing profession might be drawn up, including such things as conditions of training, compulsory registration, etc.

In this connection it should be noted that the S.A. Society of Journalists are registered under this Act and claim that it has been advantageous to them.

Disadvantages

1. Section 2 (2) of the Industrial Conciliation Act No. 36 of 1937: "This Act . . . shall not apply . . . to persons employed by the Government of the Union (including the Railway Administration) or a provincial administration . . ."

In view of this a very large number of nurses would be excluded from the protection and benefits under the Act.

2. Our relationship with the International Council of Nurses would be seriously affected.

3. Such a step would probably be unacceptable to many nurses resulting in a cleavage in the ranks of the profession.

4. The exclusion of Bantu Nurses.

5. Higher subscription.

AN ACT OF PARLIAMENT.

Advantages

1. "Closed Profession" principle which would prohibit the practice of nursing habitually and for gain by non-registered nurses, as all branches of nursing would be registered or enrolled in their own categories.

2. STUDENT NURSES—Such a Bill would provide for the protection, welfare, conditions of employment, etc., of nurses in training.

3. AUXILIARY SERVICES & ASSISTANT NURSES.—The protection, control, welfare and enrolment of these nurses could be included in the Bill.

4. Special legislation could be so framed as to meet the peculiar needs of the profession and would obviously be more advantageous to nurses than the adaptation of existing legislation under the Industrial Conciliation Act, which was not framed to include such a body.

5. The Association could in effect be given all the powers which its registration as a "Trade Union" would achieve.

6. Through such a Bill provision could be made for:—

Control of the profession by nurses through the medium of a Nursing Council, the functions of which would include control of:—

- (a) Conditions of training.
- (b) Registration and Qualifications.
- (c) Conditions of employment.
- (d) Discipline.

THE DECISION WILL HAVE TO BE MADE BY THE NURSES OF SOUTH AFRICA WHO NOW HAVE THE OPPORTUNITY OF SHAPING THEIR OWN DESTINIES.

§ Durbow

Figure 6.4 Memorandum sent to South African nurses during the 1942 trade union crisis (DENOSA 1942f)

SATNA's information campaign and mass meetings with nurses all over the country were successful. Membership numbers increased because male nurses were invited to join SATNA and hospital matrons persuaded their staff to join the professional association. The SATNA branches gave its Executive Committee a mandate to strive for an Act of Parliament that would provide nurses with the long-desired independent nursing council. This course of action would create a closed profession. The SATNA Executive Committee thereupon prepared a draft bill, which was introduced in Parliament as a Private Member's Bill by Mrs VML Ballinger (an independent, non-party member with liberal views) on 23 March 1943. Due to active campaigning by Mrs Cribb and Mrs Ballinger and support from Dr Peter Allan (Secretary for Health and Chief Health Officer of the Union), the Minister of Welfare and Demobilisation (Mr Harry Lawrence) concluded that the proposed bill was important for the welfare of the public and the nurses. He therefore adopted the Nursing Bill as a government measure, but requested that some amendments be made (Marks 1994:131; Mellish 1990:127; Searle 1982a:43, 52). The first Nursing Act (45 of 1944) was passed through Parliament unopposed and was promulgated on 6 June 1944 (Searle 1982a:43-44). This meant that South African nurses finally had an independent governing body: the SANC, which would manage the training and registration of nurses and exert disciplinary control over the profession.

The Nursing Act (45 of 1944) also enabled SATNA to convert into the SANA: a professional association that all practising South African nurses (registered and student nurses/midwives of all races and gender) had to join (Radloff 1970a:33-34; Searle 1982:44). SANA was charged with raising the status of nurses and providing the Union with "an efficient and adequate nursing and midwifery service" (South Africa 1944: lxx). South African nursing became a closed profession, with compulsory membership of one professional association. Non-registered (untrained) persons could no longer work or call themselves nurses. The right to strike was not given to nurses/midwives, as both SATNA/SANA and the national government were opposed to nurses participating in strikes. If nurses had been members of a registered trade union, they would have had the right to strike, as provided for in the Industrial Conciliation Act (11 of 1924) (Lubanga 2014; Marks 1994:129-130; Searle 1987b:285).

6.4 A DEFINING MOMENT IN HISTORY

The Witwatersrand junior trained nurses' and nursing students' grievances were similar to the issues raised at the August 1942 SATNA conference in Klerksdorp. At that conference, the Association expressed its concern about nursing students being exploited in the workplace. As reflected in Miss Alexander's presidential speech, the students did have a communication channel within SATNA, as a specific student section was established precisely to support them in socio-economic, professional and training matters (Searle 1972:247; Trained Nurses' Conference 1942:1). However, SATNA chose to address junior nurses' concerns by using formal channels, which excluded them from participating in discussions (Searle 1982a:41-42). This contributed to the junior nurses' view that a trade union, instead of a matron-dominated association, would allow them a voice (Harrison 1982:5; Marks 1994:119, 126; Searle 1972:248). Reflecting on this period in South African nursing history 25 years later, Jane McLarty (McLarty 1969:5-6) noted that the students chose to seek assistance outside the profession rather than ask SATNA for assistance. Searle (1972:248-249), however, was of the opinion that the strict nursing hierarchy and discipline prevented (non-member) student nurses from actively participating in SATNA. In this way, an opportunity to influence the professional socialisation of student nurses was lost and the seeds of the trade union crisis were sown. The researcher deduces that the attitude toward students as members of the association might in part derive from a tradition established by its founding members. In the *South African Nursing Record* of June 1919, an article addressed to the probationers (student nurses) stated: "We want them to to [sic] train with the idea that membership of this Association is a privilege that qualification will confer upon them" (TNA and registration 1919:169). Furthermore, a qualification was not enough to guarantee membership of the Association – registration was essential. "We are very jealous of our status" (TNA and registration 1919:169).

The potential divide in the nursing community could not only be explained in terms of ineffective communication. Cultural and class differences also came to the fore. Since 1891, when state registration for South African trained nurses had begun, English-speaking nurses (perceived as being elitist) were the driving force in the development of the first successful professional organisation. Then in the 1940s, due to the influence of WWII on nurses' working conditions, the mostly middle-class Afrikaner and junior nurses voiced their displeasure about the treatment they suffered at the hands of these elitists

(Mellish 1985:42; Marks 1994:74, 126-127; Searle 1972:248). Such dissatisfaction made the Afrikaans-speaking nurses susceptible to trade union influences. Marks (1994:131, 133) argued that it contributed to the Nursing Act (45 of 1944) being passed without opposition by the South African Parliament. In the 1930s and the 1940s, the majority (almost 70%) of White nurses in South Africa were Afrikaans-speaking. There were rumours that Afrikaner nationalists planned to make South African nursing reform an election topic (Lubanga 1991:56-57; Marks 1994:8-9). Thus, astute nurse leaders used these political concerns and the unsatisfactory conditions in the country's health care system to further their agenda of obtaining professional independence for nurses. Nowhere was lobbying by nurses more evident than in this period of South African nursing history. Marks (1994:113) refers to the "deliberate politicisation and mobilisation of white nurses". Members of the House of Assembly were contacted. Influential family members and friends provided financial support and were requested to influence politicians. All those contacted were informed that South African nurses desired an independent governing council and a professional association with compulsory membership (Searle 1972:252).

Black and Coloured nurses (the majority in modern-day South Africa) did not participate in the 1942–1944 trade union debate, in part because there were so few of them. Mellish (1985:49) states that in 1957 (15 years after the trade union crisis) there were only 433 *trained, registered* Black nurses. Other factors such as culture, class and education also excluded from the debate the approximately 800 registered *and* hospital certified Black nurses practising in the 1940s. When it was suggested that BTNA should be granted affiliation status (implying a formal relationship and exclusivity), the elitist SATNA rejected the proposal, because most of the BTNA members were not fully trained, but held only hospital certificates. The best that could be offered was associate membership (less formal and offered to outsiders) (DENOSA 1942a:5; Marks 1994:133; Searle 1972:275).

Although the Nursing Act (45 of 1944) effectively ended the trade union crisis, it also created a dilemma. The stipulation that membership of the newly established SANA was compulsory for all practising nurses in South Africa drew criticism (Lubanga 2014; Radloff 1970a:39). It implied that nurses, regardless of race or level of training, were engaged in a form of closed-shop agreement with the national government, as only SANA members could practise the art of nursing in South Africa (Rispel & Motsei 1988:12-13). Yet, nurses opposed the formation of a trade union in 1942 precisely because they objected to such

closed-shop principle. They believed that a workers' trade union would not value the professional ethics of nursing, nor support their philosophy of service. Radloff, Searle's student, argued that nurses themselves asked for compulsory membership because it protected them against the danger of trade unionism (Radloff 1970a:39). It was believed that a trade union would interfere with staff grading, staffing ratios and overtime, and even dictate the workload of nurses without due consideration of the patient. Searle (1972:250-251) herself concluded that a closed-shop principle would only have been acceptable if it was in the hands of professional persons who recognised that occasionally exceptions should be made. In this, South African nurses followed the example set by nurses in the United Kingdom (UK) and the USA, who also feared that a trade union would have a negative effect on the professional status of nursing (Marks 1994:128-129).

A collective voice would further provide nurses with a position of strength in any bargaining structure. In this case, strength lay in numbers: SATNA started in 1914 with 30 members and by 1942 it had 2 214 members. The Nursing Act (45 of 1944) placed the responsibility to bargain as a collective in the hands of SANA, which by 1955 had 19 544 members, including junior members (students) (Union of South Africa 1955:94).

The Nursing Act (45 of 1944) stipulated that changes to the SANA constitution had to be approved by the Minister of Health. This included regulations about membership and voting rights, establishing branches and fiscal management of the organisation (South Africa 1944: lxxii-lxiv). Although no longer controlled by the Medical Council, South Africa's only acknowledged professional nursing association was now controlled by the government.

The effect of the 1942–1944 trade union crisis on the psyche of a still-developing nursing profession was immense. Searle (1987a:303) argued that the 1942 trade union crisis and the resulting Nursing Act (45 of 1944) represented the struggle for professional independence. What started as a protest about working and training conditions and SATNA's perceived lack of representation of junior nurses culminated in a victory for nurses' professional independence and status. Only in the 1980s would nurses' struggle to improve their socio-economic status gain momentum (Marks 1994:128-129; Searle 1972:251; Searle 1982a:44-45). Even then the outgoing SANA Vice-President would lament the "*parish-pump mentality*" of some nurses who focused on problems of a "petty, domestic nature" (Harrison 1982:5). Rather, she said, the association must aim to create

a nursing corps that provided quality health care to South Africans and negotiate on behalf of nurses from a point of strength. The professional association prioritised ideals first and job satisfaction second.

6.5 SATNA TO SANA: THE TRANSITION

The influence of liberal-minded English nurse leaders would gradually lessen until nursing was controlled by Afrikaans-speaking nurses, advised by the SAMDC and supervised by the national government.

6.5.1 Statutory control; yet interdependent

The first Nursing Act (45 of 1944) was passed by the South African Parliament on 6 June 1944 and came into effect on 8 November 1944 (Searle 1972:253; Searle 1982a:46-47). It gave statutory recognition to SATNA, which became formally known as the SANA. SATNA (1914–1944) was a professional nursing association with voluntary membership which was limited to trained, registered nurses. With the passing of the Nursing Act (45 of 1944) and with the passage of time, this would change. Membership of the new professional association (SANA) became compulsory for all practising nurses, midwives and students – regardless of race or gender. Mellish (1990:127) used the word “enforce” to describe the compulsory membership of SANA. Compulsory membership created a closed profession: nursing positions were protected and made available only to SANA members. The association regularly communicated with the South African government about matters afflicting the profession and/or society (Rispel & Schneider 1990:13; SATNA 1934a:208; SATNA 1934b:300; Searle 1987a:299). In fact, the first SANA Board meeting was held in the West Wing conference room of the Union Buildings on 10 November 1944 (Searle 1982a:53). Governmental communication was important, as any changes in SANA’s regulations had to be approved by the Minister of Health (Du Preez & Brannigan 1991:39; Rispel & Schneider 1990:32). SANA members could vote for change; the government approved it.

When the Nursing Act (45 of 1944) was drafted, it was envisioned that SANC would continue to have a close working relationship with the SAMDC: each having two representatives on the other’s board (Searle 1972:233-234; Searle & Pera 1993:7-8). At that time, South African nurses were the only group in the world to have such a close

working relationship with their counterparts in the medical profession. Searle (1982a:45) defended this working relationship by stating that “South African nurses ... are entitled ... to share, at statutory level, in the control of the profession of medicine”. That nurses had a degree of influence is evident in the then Transvaal (modern Gauteng province) Hospital Association changing its constitution so that a SATNA member, with “full voting powers”, could serve on the Executive Committee. SATNA was also consulted about the training curriculum for nurses in the province (DENOSA 1943:1).

In 1946, the Nursing Act (45 of 1944) was amended to strengthen the control of SANC and SANA over the profession. The council and the association jointly formulated the rules of conduct for South African nurses. Uniforms were prescribed and control over nursing agencies confirmed. The control over the nursing agencies finally put to rest SATNA’s struggle (note Chapter 5, sub-section 5.2.4) to stop unqualified persons from calling themselves nurses and working at a reduced fee. These changes were supported by the SAMDC, with the Editor of the *South African Medical Journal* stating that it “has the blessing of the SA Medical Council” (Nursing Legislation 1946:1).

6.5.2 Liberalism vs conservatism

Amongst the SATNA leaders there were those, such as Jane McLarty and Sybil Marwick, who were liberals at heart (Marks 1994:136-137). Jane McLarty, for example, organised a talk (presented by her sister) about South African women’s political identity for the SATNA Witwatersrand branch of which she was the chairperson (Women and Citizenship 1943). It was such a liberal, Jane McLarty, the last President of SATNA, who became the first Chairperson of the new SANA (Searle 1982a:53).

The spirit of liberalism is also evident in the first Nursing Act (45 of 1944), which did not have any racial or gender exclusions: all South African nurses could vote for SANA and SANC Boards (Lubanga 1991:57-58; Marks 1994:123-124; Rispel & Schneider 1990:25; Searle 1982a:49). Perhaps the best example of the SATNA’s liberalism resided in the politician they chose to introduce the first Nursing Bill in Parliament (note sub-section 6.4.2.4 of this chapter). Mrs Margaret Ballinger was one of seven liberals in Parliament, designated to represent Black South Africans under the Representation of Natives Act (12 of 1936). This role she fulfilled until May 1960, when this (and any other) form of Black representation in Parliament was abolished. Mrs Ballinger was an outspoken opponent

of the government's segregation policies, and in 1953 would become one of the founding members of the multiracial Liberal Party. Other founding members of the party included her husband, Senator William Ballinger, and the South African writer Alan Paton (author of *Cry the Beloved Country*) (Grundlingh 1993:300; Mouton 2007:45-60; Welsh 2000:412). Mrs Ballinger received SANA Honorary Life Membership in 1958 for her contribution in presenting the first Nursing Act (45 of 1944) to Parliament (Radloff 1970a:95).

The Nursing Act (45 of 1944) might not have contained any reference to racial segregation, but liberalism had its limits. The closed-shop principle enshrined in the act made membership of SANA compulsory for all nurses, yet Black members did not enjoy all the support and privileges that their White counterparts did. Although SANA did speak up to have Black nurses' position in customary law revised, the same nurses could not access SANA's old age or holiday homes. Furthermore, on instruction from the SANA Board, their letters in which they made objections to unequal salaries and inadequate training facilities were not published in the *South African Nursing Journal*. The explanation given was that letters of a political, religious or racial nature would not be published (Marks 1994:134-137). Such supervisory notions can in part be explained by the social status given to Black people since colonial times (note Chapter 5, subsection 5.3.1).

SANA's influence on nursing education standards advanced nurses' professional status and provided quality nursing services to some South Africans, but it also caused the post-war nursing shortage to be prolonged. At the 1955 Select Committee hearings about the proposed Nursing Amendment Bill, the Cape Provincial Administration declared that SANC "has allowed idealism to blind it to the practical issues involved" (South Africa 1955:119). Post-WWII South African nurse leaders were confronted with a conundrum: the nursing shortage and poor standards of care had to be resolved so that service to society could be improved. SANA maintained that the quality of nursing care should be improved by training educated candidates. Unfortunately, few applications for nurse training were received.

The war had changed the role of women in society; they were more employable, and they had more choices of work (Radloff 1970a:36). Furthermore, the segregationist influence that in later years would divide the South African nursing profession became evident in the attitude about the training of Black nurses. Radloff (1970a:42-43) maintained that

SANA in the post-WWII years advocated the training of Black nurses to relieve the shortage so that the community would receive “better health services from members of their own cultural group.” (note sub-section 6.3.1 of this chapter). Such increased training efforts had to occur without the educational entry requirements being lowered. It was believed that raised expectations would attract the right calibre of candidate. However, this belief failed to consider how small the number of Black candidates with the desired educational background in the post-war years was. In 1950, South Africa had 4 873 Black children (male and female) in Standard VIII (Grade 10) and only 439 in Standard X (Grade 12) (Searle 1972:277). The provision of quality nursing care to most of South Africa’s population therefore remained inadequate.

SANA’s educational ideals caused practical challenges such as finding suitable candidates who could complete the prescribed duration of training. To illustrate: when St Monica’s Home commenced with the training of midwives in 1917, the course duration was seven months. Over time this gradually changed to accommodate the training of two categories of student midwives. Those with no previous nursing training (untrained) were taught midwifery for a duration of 18 months (later two years) while the general trained nurses were taught for nine months (later one year). The influence of the professional nursing organisation on the standards of education and practice then became evident. After considering the midwifery syllabus for untrained nurses and the practical difficulties of teaching it, the mission hospitals decided to only accept general trained nurses for the midwifery course (DENOSA 1934:4; DENOSA 1938:1; Gelfand 1984:97, 103). This implied that a higher calibre of midwife could be produced, although the number of trainees (and subsequently trained midwives) lessened.

Shortly after the end of WWII (in 1946), the influence of liberal British nurses in SANA diminished, when Jane McLarty and Sybil Marwick were replaced by two South African trained nurse leaders. Miss MG Borchers (matron-in-chief of the South African Military Nursing Service during WWII) and Miss CA Nothard (a V.A.D. in WWI) were elected SANA Chairperson and Treasurer respectively (Marks 1994:136-137; Searle 1982a:53-54). That the South African nurses’ governing body (SANC) and its most influential professional association (SANA) enjoyed a close working relationship was evident in that Miss Nothard was also the President of SANC. In fact, Marks (1994:136) concluded that Miss Nothard “overshadowed” the SANA chairperson. The close working relationship between SANC and SANA had been in existence since the establishment of the two

bodies in 1944. The SATNA (which became SANA) gave the new SANC (which had no funds) £1000 so that it could commence with its function of regulating South African nursing. In later years, SANC paid the money back to SANA in the form of a financial gift (Searle 1982a:48). By using a historical inflation rate calculator (Morley [Sa]) and the current (28 October 2016)) exchange rate for the South African rand and the British pound, it is calculated that in 2016 terms, £1000 was worth ZAR 695 070.

6.5.3 The closed shop principle: not everybody agreed

Although South African nurses participated in the drive for professional independence, their activism waned after their goal was achieved. Furthermore, the voices of dissidents against the closed-shop principle became evident. Defending the compulsory membership requirement, Radloff (1970a:38-39) maintained that the dissident voices came from “those who ... had made no contribution ... but were prepared to accept the benefits which the Association secured for all nurses”. SANA leaders were therefore of the opinion that those dissident voices should be willing to assist with the cost of managing the professional association. After all, SANA made benefits possible for all nurses by being the profession’s bargaining tool.

The reasons provided for the SANA compulsory membership related to matters of service and practice. It was explained to be a means of providing the government with accurate information about the active number of nurses in South Africa, and therefore enabling effective planning of the country’s health care services and nursing training (Kotzé 2013:65; Searle 1982a:49-52). Furthermore, it gave nurses a collective bargaining voice, while being protected by the government (Radloff 1970a:34). These explanations require analysis, as there were voices of criticism against compulsory membership. A group of mental health nurses even applied for exemption from compulsory membership for all state-employed nurses. Their application was denied on the basis of the findings of the 1952 Commission of Enquiry into Compulsory Membership (Radloff 1970a:40-41).

The powers granted to SANA focused on the management of the association and its members, and the advancement of the profession (Searle 1982a:50-51):

- Establish and manage regional SANA branches
- Prescribe the rights (e.g. voting rights) and privileges of members

- Make regulations about the admission of non-practising nurses to the association
- Prescribe subscription fees
- Manage the financial affairs and assets of the association e.g. trusts and property
- Produce and manage a nursing journal
- Establish and manage sick and pension funds for members
- Investigate any claims of improper conduct by a member and bring it to the attention of SANC
- Make the necessary regulations (approved by the government) that will assist SANA in carrying out its objectives

Before SANC was established, trained nurses and midwives could add their names to the registers kept by the provincial Medical Councils and later the SAMDC. This system of voluntary registration did not provide information about untrained persons working as nurses, nor about trained (but unregistered) nurses (Kotzé 2013:65). It was therefore impossible to determine how many trained nurses South Africa had. It was also not possible to prevent untrained persons from working as nurses. Compulsory membership was an effective solution to this problem when the 1944 Nursing Bill was prepared, debated and ultimately accepted by Parliament. Once established, it became the responsibility of SANC to act as quality assurance body by keeping registers of all trained nurses and midwives and by regulating the training of student nurses and midwives (Searle 1972:252-253; Union of South Africa 1955:49-50, 152). SANC could therefore provide up-to-date statistics about registered nurses, midwives and students in training. Yet, it was SANA's role to regularly communicate with the minister about nursing matters and the state of nursing services to society. For that purpose, the SANA Board frequently made "costly and time consuming" (Searle 1982a:51-52) assessments to inform the minister. In doing that, SANA acted as the voice of the profession and the society it served. The association's close working relationship with the Nursing Council (note sub-section 6.6.2 of this chapter) would have assisted in compiling these assessments.

The South African government also deemed it important that one unified nursing association should "counter the factors which were undermining the development of an adequate nursing service" (Searle 1982a:49). What those factors were was not explained, but possibly had to do with the changing socio-political landscape and the rise of trade unionism in South Africa (note sub-section 6.3 of this chapter). Trade unions used strike

action as a bargaining tool, something that SATNA regarded as unethical in nursing. Miss Borchards testified that with compulsory membership SANA aimed to place “all nursing interests ... under one organisation” and to “dispel the threat of Trades [sic] Unionism” (Union of South Africa 1955:92).

South Africa’s socio-political dynamics contributed to African nurses becoming politicised in the 1940s (Lubanga 1991:55; Marks 1994:110). In contrast with Afrikaner nurses, whose work-related needs could be accommodated by SANA, Black nurses’ needs were not satisfied, owing to the socio-political and economic status awarded them. This led to African nurses being inclined to consider joining the Natal African Workers’ Union in 1946 and nurses from the Alexandra clinic striking in 1947. The greatest protest action of the time started in the prestigious Victoria Hospital in Alice, Eastern Cape (alma mater of Cecilia Makiwane) in May 1949. Student nurses went on a strike to protest about perceived unfairness in working and training conditions. The nurses handed a list of grievances to the Hospital Board, one of which was that they did not have direct representation on the board. Rather they were represented by two board members (Lubanga 1991:58). Miss VM Freeman, a member of the second SANA Board (Searle 1982a:103-104) visited the college and concluded that the student nurses’ complaints had merit. The matter dragged on until September 1949, when the hospital authorities decided to close the nursing school for a while. A SANC disciplinary committee and an inquiry by the Cape Provincial Administration followed (Marks 1994:107-109). At the end of the strike, the nurses could elect their representative on the Hospital Board (Lubanga 1991:60).

The Lovedale nurses were supported during their 1949 strike by the male students from the nearby Fort Hare University College. The young women studied nursing at Lovedale hospital while young men studied at the University College. The two groups were in close contact with one another as they represented the then small Black educated elite. At this time, the ANC Youth League (formed in 1944) had a profound influence on the academic life of the university campus, and the interaction between the student nurses and their male counterparts ensured a transfusion of political ideas (Marks 1994:109-110). In his 1949 graduation ceremony speech, Robert Sobukwe, as President of the Student Representatives’ Council, referred to the nurses’ strike, calling it “a struggle between Africa and Europe, between a twentieth century desire for self-realisation and a feudal conception of authority” (Marks 1994:111).

6.6 DEDUCED FROM THE DATA: VULNERABLE INSIGHTS

South African nursing's first influential associations had a positive influence on the profession as well as on the society it served. By 1942, SATNA and BTNA had cooperated to bring change to nurses' conditions of service and to call for a formal structure, be it a nurses' council or a department of nursing, to manage nurses' professional roles. The two associations, with the support of the NCW, also put pressure on the government to provide better health care services for South Africa's Black and Coloured population.

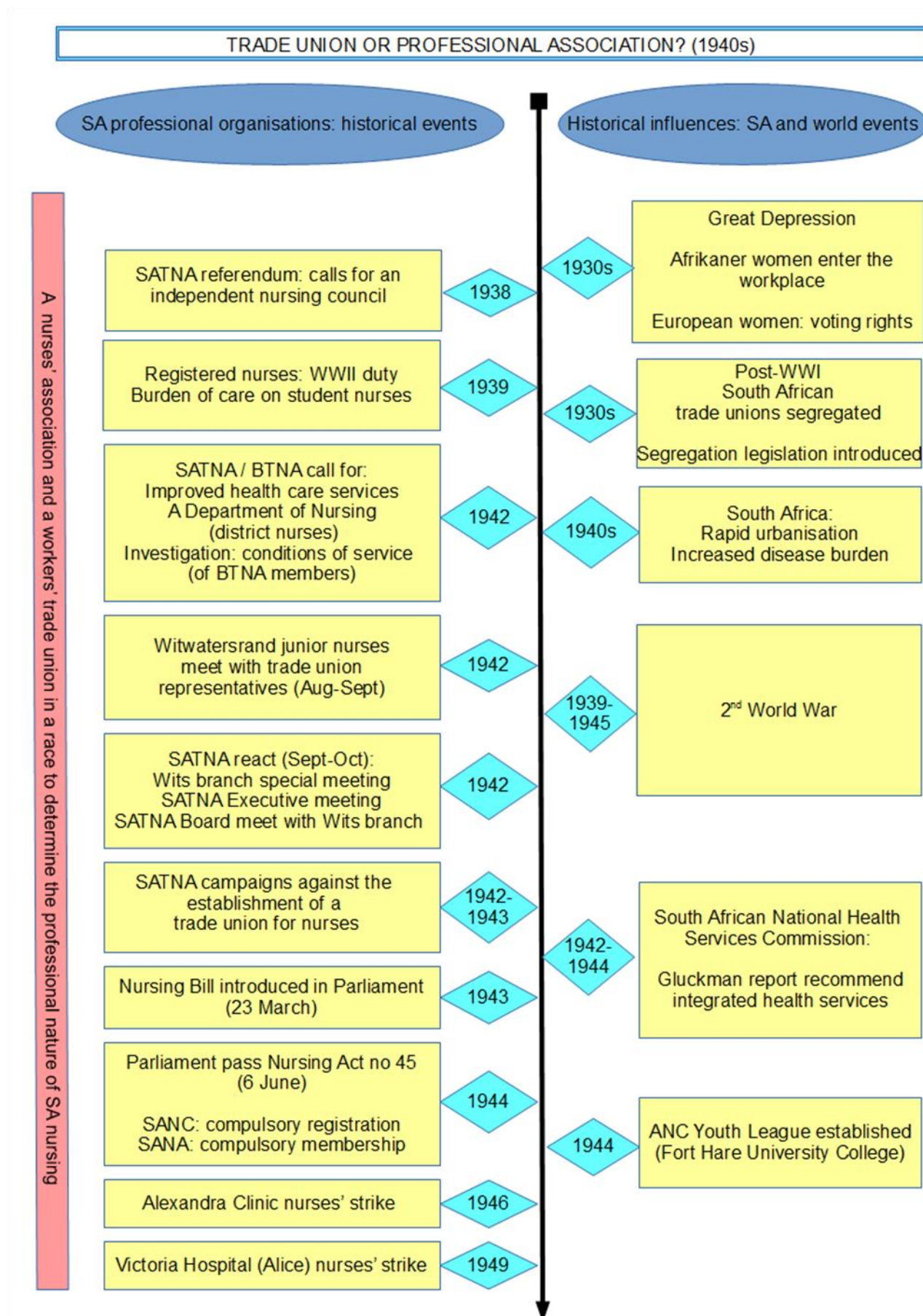
South African nurses participated in the WWII effort by providing care to the wounded and contributing money to war funds. Due to the war, a nursing shortage that had been troubling the country since the 1930s manifested itself when qualified nurses left to take care of wounded soldiers in Europe. Trained junior nurses and student nurses were left to bear the brunt of the nursing care at home, and in the process were exploited as workers. Rural communities lacked access to nurses and the care they could provide. The nursing profession was profoundly affected by this situation as nurses worked and trained in these strenuous circumstances. Aware of this, the elitist SATNA leaders chose to address the issue in a way that excluded the dissatisfied young nurses. Ineffective communication and the socio-political differences between those in charge of the profession and those doing the work made the last-mentioned susceptible to the lure of trade unionism. Junior nurses hoped that their working conditions would be addressed more effectively by a workers' trade union. In reaction, SATNA successfully campaigned against the establishment of a trade union for nurses. Instead of a trade union, South Africa's first Nursing Act (45 of 1944) established SANC and SANA, effectively creating a profession which for the next 52 years functioned with a closed-shop principle guiding its state-approved professional association.

Before the trade union crisis, SATNA and BTNA had acted as the voice of the nursing profession in socio-economic matters and set the educational standard against which nurses and the society they served could measure their professional competence. The 1942–1944 trade union crisis was pivotal in that SATNA could develop a political voice, successfully execute a campaign strategy and transform itself into SANA – the association that would dominate the professional development of South African nursing

for the next five decades. In contrast, the trade union crisis spelt the end of BTNA. The first Nursing Act (45 of 1944) stipulated compulsory membership for all practising nurses to one nursing association only, namely SANA.

From 1914 to 1944 SATNA endeavoured to raise the standard of nurse education, create a professional image for South African nurses and eliminate untrained nurses from working. The Nursing Act (45 of 1944) confirmed that they were gaining ground: voluntary registration for trained nurses was replaced by compulsory registration. SANC prescribed uniforms and insignia that could only be worn by those nurses so trained and registered. SATNA also received statutory recognition and was renamed SANA. SANA's membership numbers drastically increased due to the compulsory membership enforced by the Act. But there is always a price to pay for success: in this case, the price was a prolonged nursing shortage in the country (due to the high educational requirements) and a nursing profession at odds with itself.

Figure 6.5 provides a historical timeline that illustrates the significant events that occurred in South Africa, the world at large, and its influence on the development of South Africa's professional nursing organisations.



6.7 SUMMARY

This chapter explained how the 1942–1944 trade union crisis, created by socio-political differences and elitism within SATNA, was essentially a battle to determine the professional nature of South African nursing. SATNA leaders' campaign against the rising threat of trade unionism succeeded. A professional association with compulsory membership (SANA) and a formal structure (SANC) to govern the profession was established. South African nursing became a closed (shop) profession with a unified political voice. The next chapter will explore the influence of politics on South Africa's only statutory professional organisation and the consequence(s) for nurses and nursing.

CHAPTER 7

THE INFLUENCE OF SOCIO-POLITICAL EVENTS ON SOUTH AFRICAN NURSING: 1940s–1970s

7.1 INTRODUCTION

Chapter 6 discussed the influence of the 1942–1944 trade union crisis on the professional development of South African nurses. The first Nursing Act (45 of 1944) made provision for the establishment of a governing body, the SANC, and a statutory nursing association. For the nurses of South Africa, voluntary membership of SATNA was changed into compulsory membership of SANA.

This chapter records SANA's attempts to guide a young profession to professional maturity amid the national and international socio-political events of the 1940s to the 1970s. The narrative describes the main events that influenced South African nursing organisations and by extension the nursing profession. It explains how South Africa's racial segregation policies influenced the nursing profession and its organisations. The narrative further describes how this political ideology negatively affected SANA's membership of the ICN. SANA's socio-political and professional influences are summarised in sub-section 7.6.

7.2 SOUTH AFRICAN SOCIETY FROM 1944–1978

Shortly after WWII, the National Party won South Africa's general election of 1948. The new ruling political party was determined to prioritise the needs of Afrikaner people in South African society (Welsh 2000:426, 429). The election marked the start of the apartheid system, which would have significant and long-lasting socio-economic consequences for South African society at large. For SANA, it created one of the most challenging periods of its existence, and it all but crushed the fragile professional unity that existed in South African nursing.

7.2.1 The South African social and political landscape

The apartheid system was enforced by means of legislation. Laws such as the Population Registration Act (30 of 1950), the Group Areas Act (41 of 1950) and the Abolition of Passes and Coordination of Documents Act (67 of 1952) divided South African society along racial lines and demanded that Black and Coloured persons (male and female) carry reference books (the so-called passbooks) that provided information about them, such as their place of origin and their employee record. Black trade unions were not recognised (Welsh 2000:429) and the male-dominant National Party government did not tolerate opposition (Giliomee 2010:59). “[C]riticism of the regime and its policy was muted if not stilled altogether” (Scher 1993:398); the country became a “virtual police state” (Welsh 2000:448-449). Afrikaner women were expected to work within this restrictive society, attaining the ideals of nationalism. By participating in women’s movements such as the SAVF, women had a constrained socio-political voice (Blignaut 2013:604-605, 616; Giliomee 2010:59; Seegers 1993:480; Van der Merwe 2011:80-81).

Black women in the 1930s to 1950s in South Africa found themselves socially and politically in a similar position. They managed, however, to gain a measure of independence by participating in church and women’s organisations such as the multiracial Black Sash and the Federation of South African Women (FEDSAW) (the organisation which led the women’s march to the Union Buildings on 9 March 1956). Early female political voices included those of Charlotte Maxeke (1874–1939) and Lillian Ngoyi (1911–1980), who was a trainee nurse at City Deep Hospital and was later a seamstress (Mager & Mulaudzi 2011:379; Möller 2010:64-65, 67-84; Women’s roles ... 1989:105).

Black South Africans protested the National Party’s discriminatory apartheid laws, beginning in 1952 with a campaign of passive resistance under the new African National Congress (ANC) leader, Dr JS Moroka. The 1950s and 1960s would increasingly be marred by labour unrest and stayaway action. Important political events included South Africa’s withdrawal from the British Commonwealth (15 March 1961) to become an independent Republic on 31 May 1961 (Timelines of History [Sa]; Welsh 2000:455). By the end of the 1970s, the constant civil unrest, its effect on the local economy and international pressure would lead to the National Party government’s relaxation of the strict enforcement of some of the lesser apartheid laws (Liebenberg 1993:480-481; Mager & Mulaudzi 2011:372-373; Popular politics ... 1989:74). Yet social life in South Africa was

still racially segregated. This is effectively illustrated by an incident which occurred at a SANA Witwatersrand branch meeting. When a member of that branch brought a Black nurse to a meeting, the Black nurse was “tactfully ... moved to ... another position” in the hall where the meeting took place. After the meeting, the SANA Witwatersrand branch leadership decided that if such incidents occurred in future “the meeting would be cancelled”. The incident was so troubling that it was discussed at a SANA Board meeting (University Free State 1973c:12).

7.2.2 Trade unionism in South Africa

Although many trade union organisations emerged, few lasted for long and therefore Black labour remained largely unorganised until the establishment of the South African Congress of Trade Unions (SACTU) in 1955. Black workers realised that their economic advancement was dependent on an enabling political environment, and so trade unions became involved in politics. An example of a trade union’s engagement in political activity was SACTU’s co-operation with the ANC in organising a Congress of the People. This meeting, held on 26 June 1955 in Kliptown, produced the historic Freedom Charter (Mager & Mulaudzi 2011:378; Sactu, rise of 1989:77-78).

To curb trade unions’ involvement in political activities and weaken their influence, the National Party government promulgated the Industrial Coalition Act (28 of 1956). This Act prohibited the registration of new trade unions with racially mixed membership and forced existing trade unions to establish racially separated branches (Liebenberg 1980:496) (note sub-section 7.4.2.1 of this chapter). It seems to have been effective for a while, as the 1960s was a quiet period, with most trade union leaders imprisoned or exiled. In fact, by 1965 SACTU had collapsed and Black workers had no trade unions to come to their defence. Then, in 1972, a Coronation Brick and Tile workers’ strike in Durban (in the now KwaZulu-Natal province) spread to other factories in the country. It was the beginning of a period of resistance from which the Congress of South African Trade Unions (COSATU) would emerge in November 1985 (Trade unions, rise of 1989:37). This time, the government’s efforts to curb the emergence of trade unions would be unsuccessful, giving rise to the Wiehahn Commission in 1977 (Breaking the silence 1989:89-90; Trade unions, rise of 1989:37-38).

7.3 ETHICS, IMAGE AND ECONOMY

Prolific writer, academic and President of SANA from 1973–1983 (Brink 1989:141), Professor Charlotte Searle significantly influenced deliberations about South African nursing's professional status. Her numerous articles, books and speeches (see for example this thesis's references) pronounced on the philosophy of nursing, its ethical values and norms and the challenges still facing the up-and-coming profession. Searle's address (titled *Nursing Credo*), delivered on accepting the first Chair in Nursing in South Africa (Searle 1968:1-2), is still considered by many as the cornerstone of South African nursing philosophy.

Since the early 1900s, under a variety of governments, South Africa's ruling class accepted only Christianity as its moral compass. South African nursing's philosophy, historically influenced by the religious sisterhoods, was one of service to humankind. This generalised ethical stance placed the patient first and the nurse's needs (economic and conditions of service) second. The notion that nurses could go on strike and leave patients unattended was philosophically unthinkable. South African nurse leaders' philosophical abhorrence of strike action was evident during the 1942 trade union crisis (note Chapter 6) and to a certain extent influenced its decision to leave the ICN in 1973 (note subsection 7.4.2.3.4 of this chapter). In later years (1980s to 2000), globalisation and an integrated South African society would necessitate the re-evaluation and adjustment of the value system (note Chapter 8) that had dominated nursing from the 1950s to 1970s (Pera & Van Tonder 2011:4, 11).

SANA's activities and its influence on the South African nursing profession must therefore be viewed against the background of a strictly controlled political system (apartheid), in which the social position of women and religious (Christian) views were conservatively defined. Such historical context clarifies Radloff's (1970a:16-17) declaration that SATNA and its successor SANA

“would do its utmost to maintain high ethical standards and at no time would it be prepared to jeopardise the public welfare in the interest of the nurse. The Association was prepared to rather prolong negotiations until mutually advantageous agreement could be arrived at. This deep sense of responsibility for the welfare of the community has characterised the dealings of the organised

nursing profession from the very beginning and is still the keynote in its approach today”.

SANA’s unwillingness to engage in political activism would draw criticism in later years (note sub-section 7.4.3). In a speech at a Swaziland Nursing Seminar, the SANA President maintained that a professional association must never be actively involved in politics because nurses must serve all members of the community; irrespective of race, economic status or political affiliation: “Impartial, devoted care is the core of true professionalism” (Searle 1971:10).

The image of nursing was by no means an established concept. In the early 1970s, some in the South African medical fraternity questioned the apparent inferior image and status that nurses had (Burger 1971:758). South African nurse leaders responded to this, saying that issues such as a greater demand for health services and the inability to provide the required number of nurses to provide those health services had to be addressed (Searle 1975:35-41). In the district nursing services, the shortage of doctors and the rapidly expanding population required the role of the nurse to expand, assuming tasks that had previously been those of the physician (e.g. post-operative surgical care, midwifery and being a research assistant). Nurses in the 1960s redefined themselves “as that of co-therapist with the medical practitioner, as his professional partner” (Radloff 1970a:88). In future, nurses’ training had to include science and technology – which implied tertiary education and research activities. This in turn meant that trained nurses must reap economic reward in the form of an applicable salary, and that only trained persons should use the title nurse (DENOSA 1960a:54; Radloff 1970a:100).

It was not only the medical fraternity which questioned nurses’ professional status. Some nurses themselves did not accept the professional image as avowed by their leaders, which meant that the professional organisation and its purpose was not valued by all (Radloff 1970a:1-2). The SANA President reminded nurses that it was the professional association which protected nurses and kept them informed of changes. The professional association was the “watchdog” which assessed the health needs of the nation and communicated with the authorities about the facilities that nurses needed to perform their duties (Searle 1975:32-33). The SANA Board maintained that nurses must adapt to the changing health care environment, and initially rejected the idea that an intermediate grade for health-care workers would be beneficial (Searle 1975:24). It was still concerned

with the educational exclusivity that enabled the professional image. This is evident in the 1962 Congress resolution, that enrolled auxiliary nurses would be accepted as associate members of SANA. They could attend SANA branch meetings and vote on matters affecting auxiliary nurses (only). SANA declined a request that its 320 associate members (DENOSA 1964:2) become eligible for South African Nurses' Trust Fund benefits, citing insufficient funds as the reason. The question of a badge for associate members was left in abeyance for two years (DENOSA 1966a:29, 43; Radloff 1970a:93).

7.4 STATUTORY CONTROL OF SANA

“At the commencement of this Act there shall be established an association to be styled ‘The South African Nursing Association’, which shall be a body corporate ...” (South Africa 1944:lxix). This sentence in Part III of the Nursing Act (45 of 1944) made statutory (officially imposed) provision for a nursing association which could promote the interests of the profession and deal with all nursing-related matters. Any changes in SANA's objectives and powers therefore required a change in legislation.

7.4.1 The 1955 Select Committee to investigate the Nursing Amendment Bill

On 15 March 1954, the South African Parliament appointed a Select Committee to investigate the draft Nursing Amendment Bill then before it (South Africa 1955:iii). The Select Committee sat for two years and had three chairmen (the third chairman stated that the committee needed more time for deliberation) before producing a preliminary report in 1955 (South Africa 1955:iv-vi). The 1955 report indicated that four groups gave evidence before the Committee: SANC, SANA, the Cape Provincial Administration and the Transvaal Provincial Administration. For historical clarity and context, brief reference is made to SANC's testimony (as it influenced SANA).

7.4.1.1 *SANC evidence*

Although the Select Committee had the task to investigate the Draft Nursing Amendment Bill before it, SANC proposed a new Nursing Bill. The purpose of this new Bill would be to grant SANC discretionary, permissive (not compulsory) power to differentiate, based on race (as required by the government), between types of training – and thus types of registration. A long discussion ensued about the perceived academic abilities of Black

and Coloured nurses (in 1953 the student pass rate was 35.5%). In its testimony, SANC used socio-cultural and educational factors to explain why the nursing course *topics* for all nurses should remain the same, but that the *content* should differ (e.g. Western vs. African dietary teaching). SANC then explained that if the training course content differed, it stood to reason that the registration (of clinical skills) should also differ – although the same certificate would be issued. The SANC President, Miss Nothard, acknowledged that Black nurses opposed the idea, while some White nurses felt that such system might be beneficial. The SANC Board put the matter to the vote and was split. The decisive vote for differentiation in registration was then cast by the SANC President (South Africa 1955:5, 11, 48, 56, 58-59, 89). It implied that South African nursing's governing body was asking for discretionary power to create racially segregated registers and rolls. This decision would create racial discord in South African nursing and would complicate the profession's transformation process later, in the 1990s (note chapter 8).

The SANC also asked for control over nursing Auxiliaries who were not required to register, and so an untrained and unregulated group continued to practise the art of nursing. The Cape Provincial Administration objected to this, stating that SANC's powers over training and training facilities created financial and logistical difficulties, which hampered nurse training (South Africa 1955:12, 118).

7.4.1.2 SANA evidence

The SANC's proposed new Nursing Bill (part IV) included SANA, which implied that the Association would remain a statutory body. Section 25(1) suggested a White SANA Board and the establishment of a Black standing committee (South Africa 1955:30-32, 33, 35). SANA supported a consolidated (not only amended) Nursing Act, but testified that the proposed segregation clause was introduced by the Minister of Health, Dr Bremer. SANA was not consulted in that regard. In contrast with 1942 (the trade union crisis), the SANA Board did not conduct an active campaign to canvas members' rejection of the proposed bill. Rather it relied on its branches, calling on them to vote on their support/rejection of the proposed Bill with its segregation clause (Nursing and Racial Issue 1956:4; South Africa 1955:116-117). South African nurses' non-participation in the vote on branch level then changed the course of their history: of the 8765 SANA members entitled to vote, a staggering 71,5% (6271) did not cast their votes. The proposed Bill was supported by 1390 votes and opposed by 1104 votes. The SANA Board, being the voice of nurses in

South Africa, was mandated (by a 286-vote margin) to support the Bill (Board of the Association ... 1957:5). At the Parliamentary Select Committee hearing, the SANA representatives reflected that not all members could attend the branch meetings, and that a referendum would possibly have yielded better voting numbers (South Africa 1955:92, 109, 116). SANA later stated that such endorsement of the bill “is in direct conflict with the International Code of Ethics of the ICN” (Nursing and Racial Issue 1956:5). At the Select Committee hearing, SANA opposed auxiliary nurses becoming members of the association (South Africa 1955:113), possibly because it wished to maintain the exclusivity of having only trained and would-be-trained (students) registered nurses and midwives as members.

When asked for its opinion about the proposed separate SANC registers, the SANA representatives stated that it was a SANC matter and that SANA “did not consider the matter nor have we been asked for our opinion” (South Africa 1955:113). The researcher considers this statement as an attempt by the SANA leaders not to become embroiled in political issues. It is however, difficult to accept that SANA did not consider or discuss the issue – especially in the light of the fact that Miss Nothard gave evidence on behalf of SANC on 25-26 April 1955 (South Africa 1955:1, 59) and then formed part of SANA delegation that gave evidence on 2 May 1955 (South Africa 1955:91).

7.4.1.3 Role confusion and power play

From the 1955 Select Committee report, it is evident that the interconnected, yet distinct, roles of SANC and SANA were not always understood (also note sub-section 7.4.2.3.1), and that the power of SANC was not accepted by all. As mandated by the Nursing Act (45 of 1944), SANC was prescribing students’ training conditions and approving training schools. However, in the 1950s, student nurses were still considered a workforce and therefore SANA remained involved in its junior members’ work hours and conditions of service.

An example of SANC/SANA role confusion (and perhaps role preferences) is evident in the Cape Provincial Administration’s testimony. Its representatives wanted the new Nursing Act to restrict SANC’s control (South Africa 1955:125, 129, 132-137), stating that nurses’ conditions of employment should not be dictated by them: “It must be remembered that some of the nurses serving on the council are paid officials of the

administration and for them to be able to dictate to the administration is an unsound state of affairs” (South Africa 1955:129). Furthermore, SANA must make representations and then leave decisions to the administration, because “the Association would not have the power to dictate or to lay down conditions for the recognition of training institutions” (South Africa 1955:128-129). The researcher noticed that the Select Committee asked SANA numerous training-related questions and that the association constantly referred to SANC’s standards and rules. In this way, SANA advocated a high standard of nurse training which would benefit society – and by extension enhance the professional status of South African nurses.

The Cape Administration laid the current shortage of nurses before the door of SANC and reminded them that nursing was not a parallel profession, but an ancillary one. The nurses’ examination must therefore not be too technical – something that the Directress of Nursing Services for the Transvaal declared “sheer nonsense” (South Africa 1955:136; Evidence given ... 1955:756-757). To place the nursing shortage in perspective: South Africa’s population numbered 12 million in 1953, with 13 689 (323 male) registered nurses and 8666 midwives to attend to them (Kretzmar 1954:382). Of interest is the fact that SANA in earlier years had striven to assist with the nursing shortage. The association wrote letters to all four provinces suggesting a recruitment plan and requesting funds to implement it. All four provinces declined the offer and SANA dropped the matter (South Africa 1955:113-114; 135-136)).

In its evidence before the Select Committee, the Transvaal Provincial Administration’s Dr Wassenaar explained that hospital boards (prompted by the Wolmaransstad Hospital Board) in his province were concerned about SANA’s no colour-bar policy. The hospital boards’ concerns related to the risk of a multiracial SANA Board, the implication of multiracial “social and other functions” (South Africa 1955:147) and (considering the increasing number of Black registered nurses) the possibility of a Black majority on the SANA (and SANC) Board. The Transvaal Administration therefore wrote a letter to the Minister of Health, urging amendments to the Nursing Act to curb the danger of trade unions and lessen exposure “to the danger of Communism” (South Africa 1955:148-149). In response, the minister introduced a segregation clause to the proposed Nursing Bill. Uys (1987:55) effectively summarises the socio-political atmosphere: “Due to the subservient position of women in this often authoritarian, patriarchal society, nurses did not question the system, but accepted it and worked within it”.

In her testimony, the Directress of Nursing Services for the Transvaal, the then Mrs Charlotte Searle, objected to the appointment of a medical doctor to SANC and supported the independent power of nursing's governing body. Her pragmatic support of separate SANC registers must be regarded against the socio-political background of the era (note paragraph above and sub-section 7.2.1 of this chapter). The separate SANC registers would provide statistics to determine the number of Black nurses required to provide Black nursing services (as per government's segregation policies). Furthermore, the proposed amendments would assist nurse managers in retaining White nursing candidates who otherwise would have resigned if they were to be managed by a Black registered nurse (South Africa 1955:143, 152-154).

Within the social restrictions imposed by government policy, the Directress of Nursing had to ensure that enough nurses were available to serve all sections of South African society. That meant knowing how many of each nurse category and racial origin had to be trained – while at the same time trying to retain staff. The complete segregation of nursing services was not possible due to the nursing shortage. Transvaal public hospitals were segregated; private hospitals were not (South Africa 1955:158). In her testimony, Mrs Searle's abhorrence of trade unionists and strike action that potentially left patients unattended also came to the fore (South Africa 1955:152-153). This would influence the nursing profession in later years when she became the President of SANA (note sub-section 7.4.2.3.1 of this chapter).

Although the Select Committee requested more time to finish its work, the parliamentary session ended on 6 June 1955 and therefore the committee's preliminary report was published. On 24 June 1957, Parliament approved Nursing Act no 69 and it came into force on 12 July 1957 (South Africa 1955:v-vi; South Africa 1957:2). In her welcoming speech at the sixth Biennial Congress (24-28 September 1956), the SANA Chairperson, Miss Borchers, referred to the problems facing the association and stated that "perhaps we have arrived at the crossroads in our Professional Association" (Sixth Biennial Congress 1956:20). The Afrikaans version of the speech is more revealing, as it uses the word "samesyn" (Sixth Biennial Congress 1956:21) which in the context of the historical era can be translated as "togetherness" (Bosman, Van der Merwe & Hiemstra 1984:445).

7.4.2 Nursing Act (69 of 1957)

The Nursing Act (69 of 1957) formalised racial segregation in South African nursing (Van Rensburg & Benatar 1993:101; Walker 2001:487). The SANC had to keep racially segregated registers and had discretionary power to prescribe different qualifications and nurses' insignia – something that they chose not to do (Points in Nursing Bill 1957:4-5; Searle 1987c:18-19).

7.4.2.1 Racial segregation in South African nursing

At the 1956 Biennial SANA Conference, resolutions opposing racial discrimination in nursing were tabled. The resolutions called for equality in the status of all registered nurses and midwives, opportunities for advancement, special allowances and leave, as well as salary scales. The conference delegates carried all but the last-mentioned resolution (salary adjustments). This is a significant achievement in the light of the fact that, prior to the conference, resolutions were published and sent to branches for discussion (Biennial Conference ... 1956:36-42). The delegates therefore voted at the conference as instructed by their respective branches. The *South African Nursing Journal* (Nursing and Racial Issue 1956:4-5) reported on the conference and stated that "it would be reasonable to assume ... that the majority of nurses of South Africa disapprove of discrimination in professional matters on racial grounds". However, the conference's liberalism pertaining to professional matters did not extend into the social sphere. The 1955 Select Committee report contained several references that illustrated the widespread segregationist norms of South African society. One such statement confirmed that SANA branch meetings were mostly racially separated and that it was difficult to find venues willing to accommodate a multiracial meeting (South Africa 1955:97-100, 151).

The Secretary of the "SANA Witwatersrand Non-European discussion group" wrote a letter to the South African Medical Council saying that SANA rejected the establishment of totally separated racial associations, as this would imply a loss of power. The discussion group voiced its concern that SANA might be used for political purposes and that it would lose its ICN membership. The letter further stated that few Black nurses had voted in the 1950 SANA branches' vote (note sub-section 7.4.1.2 of this chapter) and claimed that no reference was made to it in the *South African Nursing Journal*. The 1954 Biennial Conference criticised the SANA Board for that omission (Ramusi 1957a:439-

440). SANA and its discussion group's diplomatic demeanour would not have swayed the government and so nurses did what they do best: they adjusted. The first Congress for Coloured nurses was held on 17 October 1958, while the first Congress for Black nurses was held from 15-16 October 1958. (First Congress, Coloured ... 1958:10; First Congress, Native ... 1958:4).

The new Nursing Act (69 of 1957) formalised segregationist social practices (Marks 1990:6). Political control was also evident. The 1960 Biennial Congress for White members proposed that a nursing education conference should be organised and requested that educators from all races be invited. The congress received feedback that the prime minister refused the request; as a result, the education conference was "left in abeyance" (DENOSA 1962:55). Instead a proposal was submitted to the three congresses that bursaries be established for each racial group to celebrate SANA's Golden Jubilee. Also, in 1962, the SANA Western Province branch requested approval for multiracial training sessions because it would save costs. The request was not approved by the SANA Board, as the Minister of Health refused permission. He also refused compulsory membership exemption requests (DENOSA 1962:2-3, 35, 55). The SANA Board did manage to obtain scholarships for two Coloured and two Black nurses to attend the 1965 Quadrennial ICN Congress in Frankfurt, Germany. SANA also assisted the nurses of Lesotho, Botswana and Swaziland to organise their professional associations, and a SANA member served on the three countries' Nurses' Examination Boards. Department of Foreign Affairs bursaries awarded to post-graduate students from Lesotho and Rhodesia (Zimbabwe) were managed by SANA (Nursing Seminar 1971:6-7; Radloff 1970a:94).

The Nursing Act (69 of 1957) prescribed a White nurses-controlled SANA Board as well as racially segregated branches and meetings. The act made provision for the establishment of two Advisory Committees for Coloured and Black nurses respectively. The Advisory Committees were the communication medium between their members and the SANA Board. The SANA Board's composition was determined on grounds of race (White nurses only), education (registered nurses and a midwife) and gender (one male registered nurse elected by male registered nurses) principles. If the Nursing Act (69 of 1957) was not adhered to, the minister had the power to rectify SANA Board elections, nominations and appointments. It was also expected of the Organising Secretary and

other SANA officers to be proficient in both the then official languages, namely English and Afrikaans (Comparison between ... 1957:10-14; Points in Nursing Bill 1957:4-5).

7.4.2.2 ICN 1959: questions about SANA membership eligibility

Even before the passing of the Nursing Act (69 of 1957), the international and local nursing communities were discussing its implications, as well as SANA's position as an ICN member (Borcherds 1957:32-23; DENOSA 1960c:1; Madsen 1959).

The SANA Board's disquiet about the new Nursing Act deepened after it was promulgated. The board debated whether its delegates should attend the ICN Board of Directors meeting scheduled for July 1959 in Helsinki, Finland, at all. In a private letter to Miss Gwen Buttery (ICN Deputy General Secretary), Miss Radloff (SANA Organising Secretary) expressed her concerns about how the South African delegation would be received and if SANA "will be able to save" its ICN membership as "public opinion seems to have hardened so much against us" (Radloff 1959). The SANA Board could not agree on the appropriate response to a possibly hostile ICN Board meeting. In the end, they decided to send Miss MG Borcherds (SANA President) and Miss DH Radloff to Helsinki with a mandate to withdraw SANA's membership from the ICN if need be (Borcherds 1959b; DENOSA 1959b; DENOSA 1959c; DENOSA 1960a:13-14).

The ICN President, Miss Agnes Ohlson, asked the two South African delegates to stop en route in Copenhagen, Denmark, to "discuss the South African question" (Magnussen 1959) with the Chairman of the ICN Membership Committee (Miss E Magnussen) and the Chairman of the ICN Constitution and Bye-laws Committee (Miss Pearl McIver) (Borcherds 1959c:20; DENOSA 1959d:1). The SANA delegates left South Africa for Copenhagen and Helsinki with a typed guideline that explained SANA's position on the Nursing Act (DENOSA 1959b), a typed speech and an unsigned, one-paragraph letter. The letter addressed to Miss D Bridges (ICN General Secretary) and the speech announced SANA's immediate withdrawal from the ICN (Borcherds 1959b; DENOSA 1959c).

When the Membership Committee of the ICN gave its feedback to the Board of Directors in Helsinki (6-10 July 1959), three resolutions about SANA were tabled. Based on the spirit of the South African Nursing Act (69 of 1957), the three resolutions questioned the

eligibility of SANA to remain an ICN member association. Some ICN member countries felt that SANA, by separating its branches and meetings on grounds of race and colour, dishonoured the ICN ethics code and the ICN constitution (Borcherds 1959c:23-24; DENOSA 1959d:7-9).

Miss Borcherds (DENOSA 1959b; DENOSA 1959d:7-9) used her prepared guideline to explain that South African nursing's position was complicated by politics and certain organisations e.g. the Federation of South African Nurses and Midwives (FOSANAM), the Africa Bureau and the Young Africa League. Her defense rested on the belief that SANA was a purely professional association, one that was not involved in politics. In SANA's opinion, the abovementioned organisations "show a strong bias against objective thinking" (DENOSA 1959b). She argued that the ICN had admitted SANA in 1922 as a member knowing that it had only White female members. And she reminded the ICN that it should concern itself with nursing services in the world, not politics. She then challenged the ICN Board of Directors to explain in what way SANA dishonoured the ICN code of ethics and how the SANA constitution was "incompatible" with that of the ICN. The Chairman of the ICN Membership Committee and the Chairman of the ICN Constitution and Bye-laws Committee (those of the Copenhagen meeting) confirmed that neither the ICN constitution, nor its code of ethics was violated by SANA. With that, SANA decided to remain a member of the ICN (DENOSA 1959b; DENOSA 1959d:7-9). Miss Borcherds did not have to use her prepared speech and letter of withdrawal.

The outcome of the ICN Helsinki meetings was communicated in confidence by Miss Borcherds to the SANA Board. Although SANA remained a member of the ICN, the meeting (after a debate about its formulation) accepted a resolution to which SANA objected. The ICN resolution stated that (Borcherds 1959a; DENOSA 1959d:7-9; DENOSA 1960c):

- The South African government decreed that statutory professional associations (such as SANA) must be divided based on race and/or colour.
- Only White members may serve on the SANA Board.
- The ICN had an *unwritten* principle that professed equality.
- The ICN regrets the restrictions placed on SANA and hopes that SANA will continue to assist and support the professional growth and welfare of its non-European members.

- The ICN calls on SANA to prove its commitment to equality by inviting the two chairpersons of the Advisory Committees (for Coloured and Black SANA members) as delegates to the 1961 Grand Council meeting in Melbourne, Australia.

Brush and Lynaugh (1999:138) have demonstrated that the American Nursing Association (ANA) “just barely avoided ... similar criticism by restructuring its professional organizations and including black nurses in ANA membership in 1952”.

If expelled from the ICN, SANA (and South African nurses) faced professional isolation. The value of being a member-country was illustrated in the Helsinki delegation’s report submitted to the SANA Board when it met on 10-12 September 1959 (DENOSA 1959d:1-9). By being a member, SANA had access to the International Labour Organisation (ILO) (the ICN was on its special list), with which the ICN Economic Consultant had a meeting about nurses’ conditions of employment. The recommendations made after that meeting were published in the *South African Nursing Journal*. SANA also had contact with the newly established ICN Nursing Service Division, which had nurses’ economic and social needs listed as its priority. The ICN appointed a consultant with the specific task of advising national nursing associations (such as SANA) “on the development of an economic welfare programme and especially the development of a machinery for negotiation of salaries and conditions of service” (DENOSA 1959d:5). Other advantages of being an ICN member-country included access to the ICN’s newly established Education Division (the Florence Nightingale Education Division), contact with UN Headquarters, UNICEF, the World Medical Association and the International Council for Midwives (DENOSA 1959d:1-9).

The SANA Board congratulated its two-person delegation on the successful handling of the situation at the 1959 ICN meetings, but Miss Borchers privately admitted: “This has been a ghastly time and I would’nt [sic] go through it again for anything but it had to be done and we have found that we have many friends” (Borchers 1959a).

As a statutory body, SANA had an obligation to keep the government informed of issues that affected its only professional nursing association. Despite Miss Borchers’ referring to SANA as an apolitical association, its inability to remain impartial is illustrated in communication with Mr Oxley of the South African Department of External Affairs. Mr

Oxley was aware of the earlier discussions that took place at the ICN Board of Directors meeting in Rome, before the Nursing Act (69 of 1957) was passed (DENOSA 1960c:1). Reference was made to South African nursing being “in danger of being used as a political tool” and the “group of dissident non-white nurses ... who formed the Federation of SA Nurses and Midwives” (DENOSA 1959a:1). Mr Oxley was also informed about the “political flavour of the discussions” (Radloff 1960) at the 1959 ICN Board of Directors meeting in Helsinki. The SANA Organising Secretary’s letter (Radloff 1960) to Mr Oxley concluded by stating that “I ... would be pleased if you would deal with it in a manner you think fit”.

Miss Radloff’s letter confirmed that SANA did not openly challenge the government and deferred to its policies (Radloff 1970a:16-17), but it made use of socio-politically acceptable alternatives. In the 1950s delegates attended an ICN Congress, and in the 1960s the Chairpersons of the Advisory Committees and boards travelled as observers to an ICN Congress, followed by a study tour to England and Holland (DENOSA 1966a:15, 17; Radloff 1957). Also in the 1950s, the established SANA branches used their own funds to help start the association’s Black and Coloured branches. They also expressed the wish to have a continued exchange of ideas among all SANA branches (Board meeting ... 1958:6).

7.4.2.3 ICN Congress 1973: Change or be expelled

In April 1973, the SANA Organising Secretary (Miss Radloff) received a letter from the ICN Executive Director (Adele Herwitz) requesting to meet with the SANA President before the start of the 1973 ICN Congress. SANA had to bring answers to the following questions (University Free State 1973a:1; University Free State 1973b:1-2; University Free State 1973d:2):

- Question 1(a): Are SANA Advisory Committees for the Black and Coloured Nurses’ Board representatives “European”?
- Question 1(b): What matters were sent to the SANA Board by the two Advisory Committees – and what actions were taken on these matters?
- Letters and decisions based on Nursing Act (69 of 1957) were sent to the ICN on 25/3/1971. Please provide the ICN with revisions/additions to the Act.

The ICN–SANA meeting was requested because the Swedish Nurses’ Association lodged a complaint of racial discrimination against SANA (University Free State 1973b:3) and the matter was referred to the ICN’s governing body, the Council of National Nursing Associations Representatives (CNR). If a proposed amendment of Article 1, section 2 of the ICN constitution was accepted, the ICN would recommend investigations to check if all member states complied with the constitution. The proposed amendment stated that the ICN functioned ‘unrestricted by considerations of nationality, race, creed, colour, politics, sex or social status’ (University Free State 1973b:2). The basis of the Swedish Nurses’ Association’s complaint rested on the fact that SANA (and SANC) *requested* racially discriminatory practices, as evident in the 1955 Select Committee on the Nursing Amendment Bill report and Assembly Debates of Parliament (11-15 June 1957). The SANA President later explained to the SANA Board that the copies of the 1955 Select Committee report given to ICN members had “significant omissions” (University Free State 1973b:3).

7.4.2.3.1 Meeting between the ICN Board of Directors and SANA (9 May 1973)

The three SANA Board representatives (President Searle; Vice-President Harrison and Deputy Executive Director du Plessis) met with the ICN Board on 9 May 1973 and handed over comprehensive evidence as requested to questions 1(a)–(b) (University Free State 1973a:1; University Free State 1973b:3; University Free State 1973c:2, 5-6, annexure 1). The ICN Board apparently confused the functions of SANA with that of SANC, and therefore the SANC’s separate registers, which were used to establish SANA’s voters roll, remained “a thorny issue” (University Free State 1973b:6). The SANA President explained to the ICN Board that she could only implement the Nursing Act (69 of 1957) rules “as they relate to the SA Nursing Association” (University Free State 1973b:6). It was conceded by the ICN that the separate registers assisted SANA to identify needs and the action required “to develop the non-White nursing group” (University Free State 1973b:6).

At the time of the 9 May 1973 meeting, the discussion about SANA not honouring the ICN Constitution could not be held because the amendment to Article 1, section 2 of the ICN constitution was not yet approved. The discussion therefore shifted to the ICN’s 1971 acceptance of the UN Human Rights Declaration – of which SANA was a participant (University Free State 1973b:6-7; University Free State 1973c:2; University Free State

1973d:2). The ICN Board felt that SANA was denying the Black nurses of South Africa membership of its board, even though they were compelled to be members of SANA (Brush & Lynaugh 1999:152-153). It also accused the SANA Board of neither taking any action to rectify the offending legislation nor opposing the South African government's policy. According to the SANA President, the question was asked: "Why don't you demonstrate?" (University Free State 1973b:8).

In anticipation of such arguments, the SANA delegation prepared a response (University Free State 1973b:9-10; University Free State 1973d:3). The SANA President stated that the Association would not lead its members into confrontation with its government: "I was not prepared to destroy the nursing profession by involving it in politics". Nurses, as in any country, must continue to function "within the framework of our country's laws" (University Free State 1973b:9). Protest would bring nurses and nursing into the political arena – which would be harmful to the profession and the society that nurses served. South African nurses preferred not to use "Trade Union tactics" and that they did not "bargain with the lives of our [their] patients" (University Free State 1973b:8). SANA considered strike action as unethical.

The SANA President further explained that the South African government had decided on a course of separate development. SANA therefore had to prepare its nurses for independence in separate states. SANA would assist nurses in these separate states with funds so that they could create their own nursing associations (note sub-section 7.4.2.3.3 about SANA's expansion programme). "Some day, perhaps, there might be a regional group, e.g. a confederation of Southern African Nurses' Associations" to discuss mutual interests (University Free State 1973b:10).

According to Searle, the ICN Board of Directors Chairman explained to her after the meeting concluded that she had not asked SANA if it wished to voluntarily withdraw from the ICN, because the ICN Board of Directors did not want that. Rather the aim was to use the threat of expulsion "to give SANA a weapon with which to fight the South African Government" (University Free State 1973b:11). To the SANA Board, she stated that "the irresponsible, solely politically motivated arguments saddened me" (University Free State 1973b:8).

7.4.2.3.2 Closed session of the ICN Council of National Nursing Associations Representatives (12 May 1973)

The Swedish Nurses' Association withdrew its proposal that SANA voluntarily withdraw membership or be expelled. Instead, it supported the ICN Board's proposal that SANA be given until 1 January 1975 to amend the regulation that prohibited Black nurses from serving on the SANA Board (University Free State 1973b:12; University Free State 1973d:1). If SANA was not compliant on that date, it would be expelled. The CNR members' debate on the issue continued for three hours, with some of the members stating that the ICN was "involving itself in the political arena" (University Free State 1973b:12). The SANA President concluded that "this is not the fault of nurses, but of the society to which they belong, and of which they are law-abiding citizens" (University of Free State 1973a:6; University Free State 1973b:15). But in the end the CNR accepted the ICN Board's proposal with "an overwhelming majority" (University Free State 1973d:1,3; University Free State 1973b:16). SANA had to make the required changes before 1 January 1975 or be expelled.

According to the SANA President, many presidents of associations after the meeting confided that "they were very much in the dark as to the 'why's' and the 'wherefores' of the whole issue" (University Free State 1973b:11). She also explained that many delegates after the meeting confided to her that they had to vote in favour of the ICN proposal to support their governments, to protect their relationship with those governments and to keep their jobs. "I realised that nursing like everything else was in the grip of world politics and I did not hold this against them" (University Free State 1973b:13). Brush and Lynaugh (1999:151-153) explain that the ICN itself was under pressure to comply with the United Nations (UN) Universal Declaration of Human Rights. Due to the ICN having member states such as South Africa, Rhodesia and "Portuguese-dominated African territories" (Brush & Lynaugh 1999:152) who were seemingly not honouring the Human Rights Declaration, the United Nations Educational, Scientific and Cultural Organisation (UNESCO) considered suspending its alliance with the ICN. The ICN had to weigh up the importance of national and international political matters – and respond appropriately.

7.4.2.3.3 Open session of the ICN Council of National Nursing Associations Representatives (14 May 1973)

At the open session of the ICN Congress, the president's report, the executive director's report and the financial report were presented and discussed.

The ICN President explained that the organisation's membership had weakened in the period between 31 December 1968 and 31 December 1972. This had had a negative effect on the organisation's income and its ability to contribute to the betterment of nursing. She made a strong plea that ICN membership be extended to all types of auxiliary nurses – a step which would boost ICN membership and its financial position (University Free State 1973a:6; University Free State 1973b:18-20).

The SANA President (University Free State 1973a:7; University Free State 1973c:5) later explained to the SANA Board that, according to the ICN financial report, there was an increase in "ordinary expenditure" from 1962 to 1972, while the ICN's income from dues increased by only 15%. She stated that the 1973 ICN budget deficit "is a serious one" (University Free State 1973b:20). The vote about membership of auxiliary staff and an increase in membership fees was therefore of the utmost importance. The USA and the UK "led the attack on the proposed increase in dues" (University Free State 1973b:21-22), giving several reasons for their objection to the proposal, including that currencies' devaluation made the financial strain for membership associations difficult to bear (ICN dues were calculated in Swiss francs). The UK openly threatened to withdraw. SANA also objected, stating that its financial contribution was already larger than 43 smaller member countries combined: it had the fifth-highest membership cost and paid R9 695 for its 1973 membership (Harrison 1973:7; University Free State 1973c:4). SANA could not contribute more, as it needed funds for its expansion programmes. Adding lesser categories of nurses would be unaffordable (University Free State 1973a:10-11). The CNR rejected the proposed increase in dues, leaving the ICN in "serious financial difficulties" (University Free State 1973a:8, 11; University Free State 1973b:22; University Free State 1973c:5).

7.4.2.3.4 Confidential SANA deliberations about ongoing membership of ICN

In her feedback to the SANA Board, its President explained that although the CNR rejected the increase of ICN membership dues, it did accept the proposed new ICN

definition of “nurse”, which meant that enrolled nurses and auxiliary nurses were eligible for ICN membership. According to Searle, the ICN President said that the “ICN is now able to speak for all nurses and no longer for registered nurses only” (University Free State 1973c:5). SANA, with its compulsory membership of all nurse categories, would have to pay ICN dues for all those categories (Harrison 1973:7). Using an inflation adjustment calculator, the R9 695 ICN membership fee for Registered Nurses in May 1973 was worth R531 189,05 in October 2017. Adding enrolled nurses’ and assistant nurses’ ICN fees would have totalled approximately R22 000 per year dues. (R22 000 in May 1973 was worth R1 205 380 in October 2017).

On 20 July 1973, the SANA Board unanimously recommended that the ICN dues were unaffordable and that SANA must withdraw its membership (Harrison 1973:7; University Free State 1973c:6). However, it did not vote immediately on the recommendation because the board felt that such a decision required the full consent of all SANA members (University Free State 1973c:6). A consultative meeting with the Chairpersons and Vice-Chairpersons of the Advisory Committees was arranged for the following day. The SANA Board prepared a document which served as basis for the discussion. SANA cited the unaffordability of the ICN dues and its preference to spend the money it had for development in South Africa (Harrison 1973:7; University Free State 1973c:6). It further explained that SATNA/SANA had joined the ICN “because it was a professional organisation for professional nurses.” With the inclusion of other categories of nurses, it was “no longer a wholly professional organisation” (University Free State 1973c:6). Finally, the question was asked if SANA, which opposed the use of strike action, could support an organisation which considered it appropriate action “for settling nursing demands and problems” (University Free State 1973c:6).

The SANA President assured the board that even if they withdrew from the ICN, contact with international organisations was still possible. SANA was still a member of the International Hospital Federation and of the National Council for Health Education (which had contact with international bodies). Furthermore, there were “many special interest international congresses ... open to nurses all over the world” (University Free State 1973c:7, 9). In her speech, Harrison (1973:7-8) denied that South African nurses would be isolated from international participation and unable to work overseas. She reminded nurses that their work in other countries was not dependent on the ICN; but on approval

and registration in the country of choice. Furthermore, over the years, specialities and speciality organisations had developed, which nurses could join.

On 21 July 1973, the consultative meeting between the SANA Board and the Chairpersons and Vice-Chairpersons of the Advisory Committees took place. It commenced with Mrs AN Lekgetha, chairperson of the then Bantu Advisory Committee, giving feedback of her experience as delegate to the ICN Congress in Mexico City. She was one of the seven African and one Coloured South African delegates at the conference (University Free State 1973c:7-8). She explained that after the CNR passed the resolution giving SANA an ultimatum, its African members prepared a statement and requested a meeting with the ICN President. According to Mrs Lekgetha, “the meeting was conducted in a manner not befitting nurses of their standing” (University Free State 1973c:8). During the meeting the SANA members expressed their unhappiness with the events at the Congress and handed over a memorandum to that effect.

In discussing the affordability of ICN membership, the SANA President reiterated that it would be best to use the association’s money to support the establishment of own nursing associations and councils “once self-government is granted to any of the South African nations” (University Free State 1973c:8). After lengthy discussions, the SANA Board, supported by the advisory committees, unanimously resolved to withdraw SANA from the ICN as from 21 July 1973 (Brush & Lynaugh 1999:152-153; University Free State 1973c:9, 11). The reasons for its decision were listed in the minutes of meeting (University Free State 1973c:9-10) and reflected three core issues:

- The perceived loss of professional status (sub-categories of nurses became ICN members – not only registered nurses)
- The ICN’s apparent support of strike action “as a means of settling nursing demands and problems”
- The unaffordability of ICN membership – with little benefit to South African nursing

In closing the meeting, the SANA President stated that “although the Board did not have the power to amend Acts it did have at its disposal many fronts on which to meet all its members, not only to teach but to learn, and this had to be a major task in the years ahead” (University Free State 1973c:11). In her speech explaining the SANA decision to its members, Harrison (1973:8) referred to the ICN withdrawal as “the beginning of a new

phase” and expressed the belief that South African nurses could share their expertise with their “immediate neighbours who are still developing their nursing services and who have the same socio-and economic problems pertaining to health, as we have”. As a courtesy gesture, the South African Secretary of Health, the Secretary of Foreign Affairs, Miss Borchers and Miss Simpson were informed of the SANA Board decision (University Free State 1973c:11). The SANA membership was not consulted, leading to “considerable dissatisfaction” (Du Preez & Brannigan 1991:36) and a resolution was taken, that in future members would be consulted before major decisions were made (Brush & Lynaugh 1999:152-153; Du Preez & Brannigan 1991:36).

7.4.3 Criticism of SANA

SANA had more to deal with than only international criticism. Closer to home, the association was criticised by liberal sections of South African society and from within its own ranks.

7.4.3.1 Criticism from SANA members

It is evident from discussions held at the 1956 Biennial Conference in Grahamstown that SANA members were divided about what would become the new Nursing Act (69 of 1957). One delegate expressed the view that the establishment of Die Afrikaanse Verpleegstersbond should be viewed as a vote of no confidence in SANA. Another breakaway group, the Catholic Nurses’ Guild, was also established. The then Mrs Searle concluded that these associations’ constitutions declared them cultural organisations, which did not affect SANA’s statutory position. The SANA Board accepted this explanation and decided not to investigate further, because it was the democratic right of members to belong to cultural organisations of their choice.

Instead, three resolutions were put to the conference about the equality of nurses’ status, salaries and leave, irrespective of race (note sub-section 7.4.2.1). The discussion about these resolutions included Jane McLarty’s memorandum stating her opposition to the proposed new Nursing Act. She stated that “the good fellowship which exists would be served [sic] and replaced by feelings of distrust” (Proceedings at Congress 1956:30) and cautioned that the ICN would not support evidence of racialism in nursing. She further stated her disappointment that the Black nurses’ view was not included in a memorandum sent to the Minister of Health. Miss Nothard reminded the meeting that the SANA Board

had to represent the Association as a whole (note sub-section 7.4.1.2). Although SANA members could not appear before Parliament's Select Committee as a collective, they could appear in their individual capacity. The Black representatives chose not to, as they feared victimisation. In a related matter, the 1956 Congress agreed that the board should request the government to exempt Black nurses from all pass laws (Proceedings at Congress 1956:29-30, 33, 35).

In reaction to the Nursing Act (69 of 1957), a group of Black nurses from the Witwatersrand formed the Rand Nurses' Professional Club, which later assisted in forming the multiracial FOSANAM. It held its first conference in July/August 1958 where, according to Lubanga (1991:66), "the nurses took a political stand and defended their noble profession". Lubanga (1991:67) further argued that the government of the day promoted Black nurses to senior positions in the workplace, thus placing them in a position where they "could not carry on their protests". In a letter to the ICN, the SANA President referred to the FOSANAM and declared that the Reverend Father Jarret-Kerr's inauguration speech did not accord with SANA's views. The SANA President and its Organising Secretary met with the Reverend to clarify the association's professional position. As the statutory organisation for nurses in South Africa, SANA was unable to recognise the FOSANAM (Borcherds 1958:2).

After the Nursing Act (69 of 1957) was passed by Parliament, the SANA Board decided not to hold a special congress (as requested by the Witwatersrand Branch) about the Act's implications for South African nursing. Rather, a SANA Board delegation (Miss Borcherds, Miss Nothard and the Organising Secretary) would visit all branches to reach as many of its members as possible. The board would consider the suggestion of a special congress after these branch meetings had been completed (Board meeting ... 1958:4, 6; Meeting of the Board 1957:10-11). The SANA Witwatersrand Branch also called for a new referendum, asking: "Are you in favour of this discrimination?" (Meeting of the Board 1957:10).

Perhaps the subtlest form of resistance (and/or lack of interest) was in SANA members not paying their membership fees and therefore not participating in professional activities. This was, for example, evident in the SANA membership statistics of October 1968 to March 1970, which indicate a dramatic increase in (both White and Black) members who were in arrears with their fees (DENOSA 1970:14).

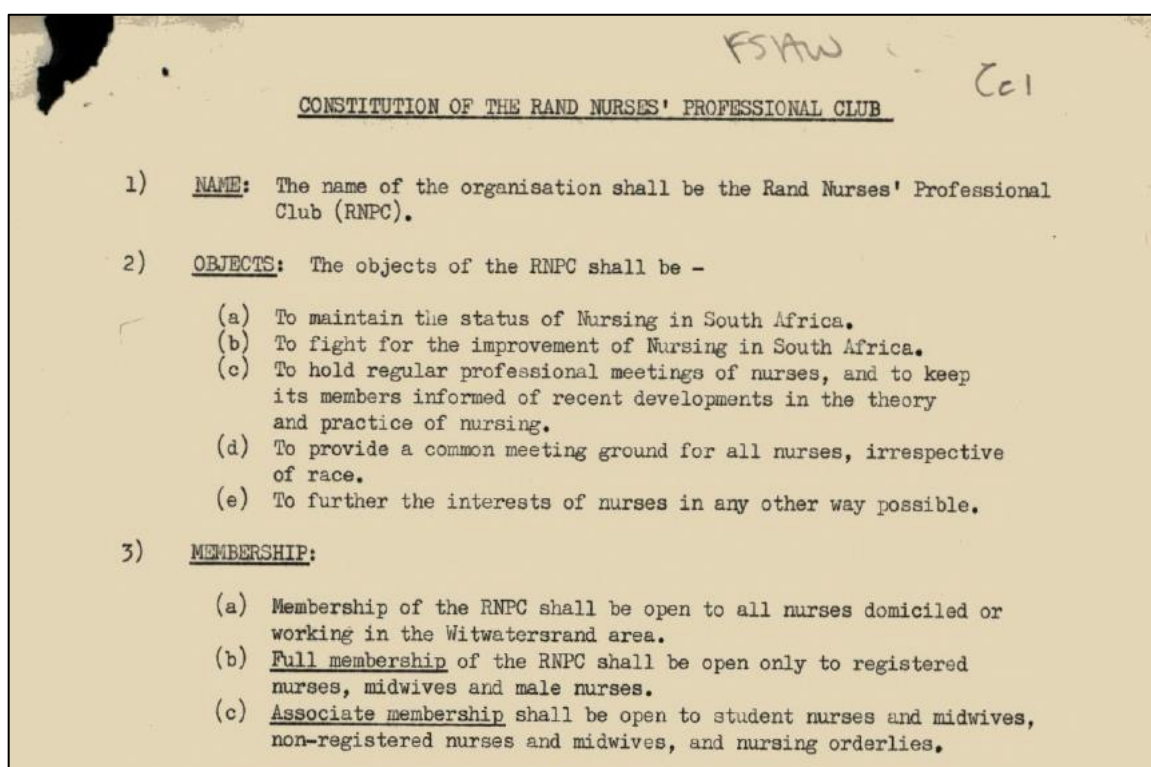


Figure 7.1 Constitution of the Rand Nurses' Professional Club
(University of the Witwatersrand [Sa]a).

7.4.3.2 The Federation of South African Women campaign 1956–1958

Although the SANA leaders abhorred strike action, throughout its existence nurses occasionally did go on strike, especially in the 1980s to 1990s (Potgieter & Muller 1998:18-19). However, the most significant protest action in which South African nurses were involved, along with non-nursing organisations, was the 1956 to 1958 campaign to protest what were commonly referred to as the pass laws.

FEDSAW was a multiracial organisation best remembered for leading the women's march to the Union Buildings on 9 August 1956. The Federation's leaders included women such as Helen Joseph, Albertina Sisulu, Lilian Ngoyi and Frances Baard (University of Witwatersrand 2006).

From 1956 to 1957, FEDSAW, the African National Congress Women's League (ANCWL) and the "SANA Witwatersrand non-European Discussion Group" communicated their dissatisfaction about the proposed new Nursing Bill (later Nursing Act 69 of 1957) and its

potential to introduce racial segregation into the nursing profession (Joseph 1957; University of Witwatersrand 1957a). The SANA Discussion Group wrote a letter to the ICN in protest. It stated that the proposed Nursing Bill would negatively affect patients if the standard of training for Black and Coloured nurses was lowered. The group objected to any discrimination on the SANA Board and stated that the new Nursing Act should honour and uphold “the principle and the practice of equality” (Ramusi 1957b) in nursing affairs. The FEDSAW Secretary (Helen Joseph) promised that the nurses’ memorandum of protest would be discussed at a planned FEDSAW Transvaal conference, and in the meantime invited the SANA Discussion Group to affiliate with FEDSAW (Joseph 1956; Nyama 1956).

A circular (dated 8 August 1957), sent to the secretaries of the SANA branches and the secretaries of the SANA “non-European Discussion Groups”, invited all interested nurses to attend a national conference of nurses planned for 2-3 November 1957. The purpose of the conference was to discuss the proposed new Nursing Bill and the possible formation of a non-discriminatory nurses’ organisation that could directly affiliate with the “International Nursing Council” [sic] (University of Witwatersrand 1957b). The circular strongly objected to the proposed racial discrimination which was “alien to the ethics and traditions of our profession” (University of Witwatersrand 1957b). It reiterated the view that the Nursing Bill would impact negatively on the profession and on South African society. It would “destroy the harmony and co-operation between nurses of different racial groups which at present exists” (University of Witwatersrand 1957b).

A second circular (dated 7 September 1957) explained that existing multiracial SANA branches were being dissolved in favour of segregated branches. The Organising Committee reminded nurses that the new Nursing Act (69 of 1957) only acknowledged decisions made by a White majority in a meeting, thus depriving Black and Coloured SANA members from decision-making powers. Nurses in South Africa’s main centres were participating in multi-racial demonstrations, and Black nurses refused to be part of separate branches and did not elect committees. In their opinion, SANA did not represent the interests of all South African nurses. The call for a multi-racial nurses’ organisation “not ... restricted by the Nursing Act” (University of Witwatersrand 1957b) was repeated. The threatening socio-political environment in the 1950s was evident in Circular no. 2. The Organising Secretary confirmed the dates of the conference and then merely stated that a conference hall for 500 persons and accommodation had been arranged.

Delegates had to meet at Park station and would be transported to the venue (University of Witwatersrand 1957b). Circular no. 2 concluded with a call that was reminiscent of the 1942 Trade Union crisis:

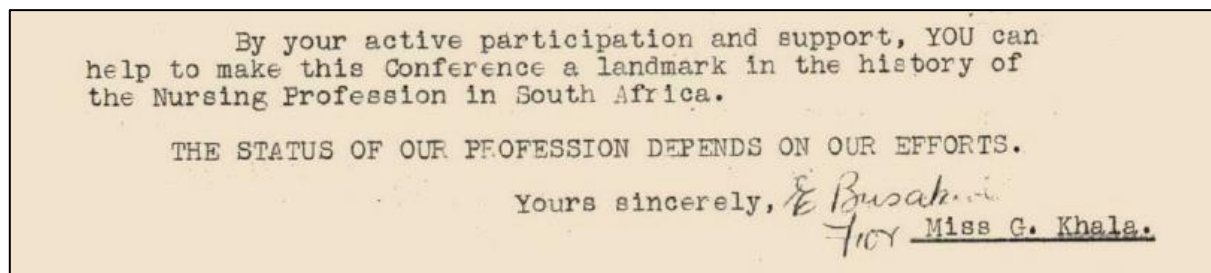


Figure 7.2: Circular 2
(University of the Witwatersrand 1957b)

The protest against the Nursing Act (69 of 1957) came to head when the introduction of racially segregated SANC registers became a reality on 1 January 1958. African women were required to have a so-called passbook, which would be used to register nursing candidates for midwifery and/or general nurse training. They had to choose between having a qualification *and* a passbook (with its implied loss of dignity and freedom) or no passbook and no qualification. Some refused to carry passbooks, such as the 120 women in Uitenhage who were subsequently jailed for two months (Baragwanath nurses...1958; University of Witwatersrand 1958a). FEDSAW and the ANCWL (Transvaal) rallied to these nurses' side, calling for the formation of a liaison committee which would organise protest marches to the hospitals threatening "to withdraw their daughters from the hospitals" (Joseph 1958a). Although FEDSAW mobilised on behalf of South African nurses, there was a greater issue at stake: "the example of nurses will easily be followed by other African women, who see their educated sisters, members of a highly respected profession, accepting passes" (University of Witwatersrand 1958b). Knowing the personal and professional risks that nurses were taking, it was decided that non-nursing organisations would manage the campaign and that no official call would be made on nurses to join (Joseph 1958b; University of Witwatersrand 1958b). They were, however, invited to send representatives to the proposed liaison committee – an offer which FOSANAM declined in a handwritten letter. The Federation hoped to join the ICN and as such could not afford to be viewed as a religious or political entity: "We are bound by a resolution of our last National Conference to fight against Passes [sic] as a nurses' Professional [sic] body only" (Khale 1958). SANA-styled exclusivity became evident.

The non-nursing organisations forged ahead and organised a march to the Baragwanath Hospital on Saturday, 22 March 1958 at 10 am (All quiet ... 1958; Joseph 1958b). A letter was sent to the Matron of the Hospital and the Principal of the non-European Nurses' Training College informing them of the purpose of the march and requesting a meeting with them (Joseph 1958c). Despite roadblocks and the presence of a large armed force, the march was completed without violence (All quiet ... 1958; Cordons round townships ... 1958). The deputation met with Miss Simpson (the Matron-in-Charge) who assured them that training and certification remained the same for nurses of all races. She also confirmed that nurse candidates did not have to provide their identity numbers when they registered for training. FEDSAW welcomed these decisions and called on SANC to repeal the racial clauses in the Nursing Act (69 of 1957) (Baragwanath nurses ... 1958; Victory in part 1958).

In a letter to the Editor of the *New Age* newspaper, the joint regional secretaries of FEDSAW (Transvaal) commended the women who had marched to Baragwanath for their courage, discipline and dignity (Joseph 1958d). Welsh (2000:452-453) concludes that "women of different races often showed a better capacity for cooperation than did their men" and that "Within fifteen years reality asserted itself, and the [Nursing] Act [69 of 1957] was quietly ignored".

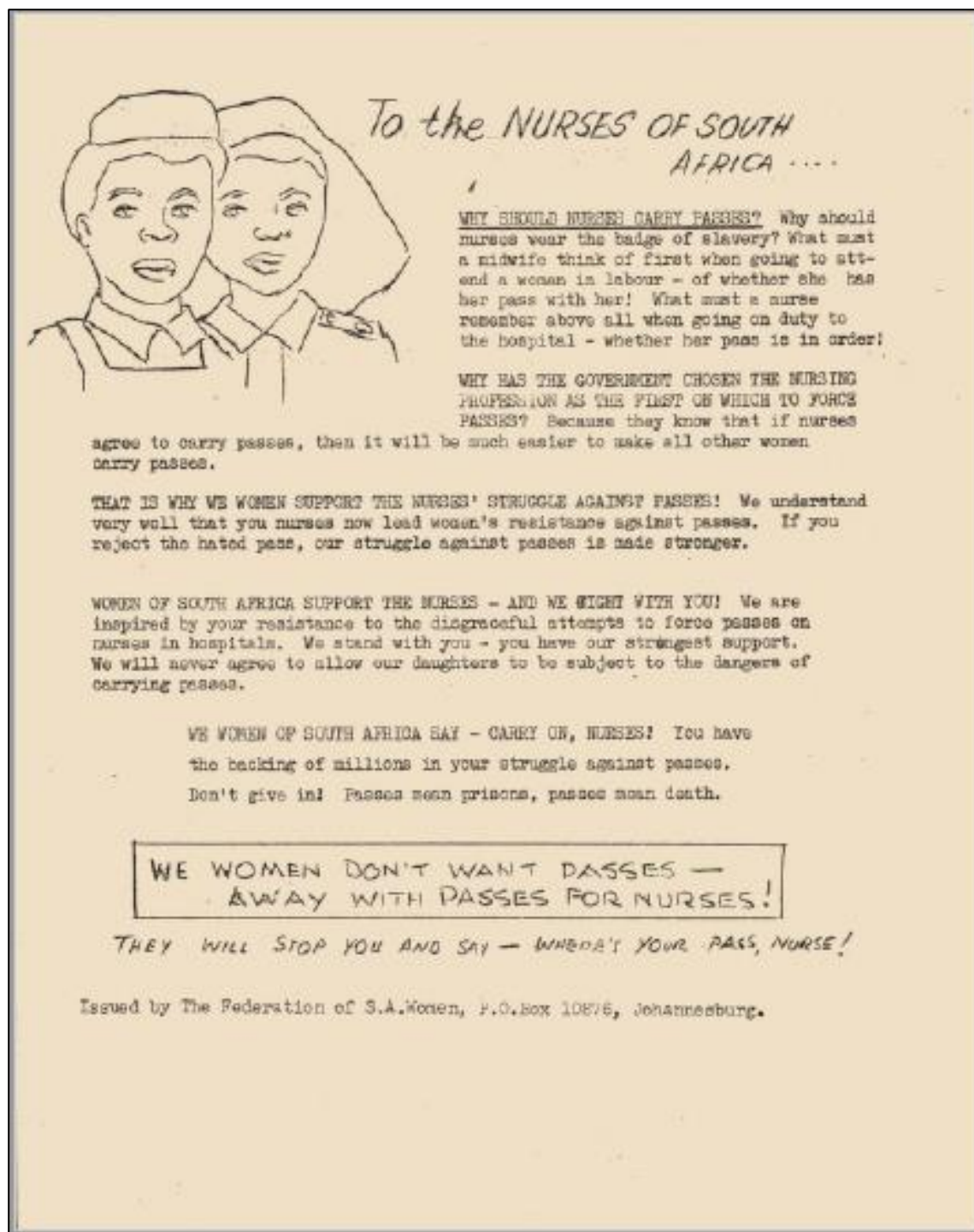


Figure 7.3 Circular issued by FEDSAW re passes for nurses
(University of the Witwatersrand [Sa]b).

7.5 SANA's CONTINUED ACTIVITIES TO DEVELOP THE PROFESSION

The extensive influence of SANA on the professional development of the South African nursing profession was evident in the association's published Biennial Board Reports. Apart from the executive committee, there were standing committees which dealt with matters such as public health, psychiatric nursing, midwifery, editorial and public

relations, medical liaison, and the economic welfare of nurses. SANA further had a standing committee for education and a National Florence Nightingale Committee of South Africa (DENOSA 1962:4-7).

7.5.1 Education and research

In the 1930s, universities did not embrace the concept of tertiary training for nurses, possibly because nursing was not considered to be a profession (Horwitz 2011:2). In the 1940s, a debate about tertiary training for nurses ensued, with some nurses themselves opposing the idea. Tertiary education for nurses therefore occurred gradually (Horwitz 2011:3-4). Searle (1975:45) refers to the “traditionalists” and the “old guard” who slowed the changes needed in nursing education. Nursing education was of great concern to SANA, because it was recognised that the economic welfare of nurses depended on the exclusivity of their skills and services (DENOSA 1966b:3).

Bearing in mind that the purpose of SANA was to enable the professional development of South African nurses, the association’s 1960 biennial congresses resolved to establish a South African College of Nursing. A sub-committee was established to investigate the matter and suggest a plan of action. By 1962, the sub-committee presented a report to the SANA Board, upon which it was decided to appoint an Education Officer as part of the permanent SANA staff (DENOSA 1962:19-20; DENOSA 1966b:9). While plans for the establishment of the College of Nursing were under way, SANA awarded grants to universities in South Africa with the aim of obtaining graduate education for nurses. Placing advanced nursing students at universities had the benefit of nurses doing formal research during their training. Additionally, nurses and the nursing profession benefited from government and university research funding. In 1966, the SANA Board recommended that the establishment of the South African College of Nursing be rescinded due to progress made with negotiations to establish a Department of Nursing and a Chair of Nursing at the University of Pretoria. Having tertiary nursing education in the public domain was also advantageous. The agreement between SANA and the University of Pretoria included a stipulation that the newly established Department of Nursing would conduct research needed by the association (DENOSA 1966b:12-17). SANA viewed the establishment of Chairs of Nursing and full Departments of Nursing as the ultimate recognition of the profession (DENOSA 1966b:12; Radloff 1970a:64). The first Chair of Nursing and Department of Nursing was established in 1967 at the University

of Pretoria, with Mrs Charlotte Searle as Professor (Van der Merwe 2011:90). The second Chair of Nursing at the then University of the Orange Free State (UOVS) was established with Miss Idalia Loots as Professor (DENOSA 1970:11).

SANA also interacted with the then Department of Bantu Education about the establishment of a basic degree for Black nurses, but was still unsuccessful by 1969. The challenge that had to be overcome was to find suitable matric candidates and clinical facilities close to a university (Post-basic facilities 1957:33; Radloff 1970a:60-61).

The drive to move nursing education from the provincial hospital department to a provincial (even national) level then commenced seriously (Radloff 1970a:54). The SATNA/SANA's drive to establish post-basic nursing courses in the clinical, administrative, educational and primary health-care (volksgesondheid) fields had a considerable influence on the swiftness of professional development of nursing in South Africa. Prior to 1914, South African nurses had had to travel to England to attend post-basic courses (Searle 1964:104, 108-109; Post-basic facilities 1957:33). The researcher concludes that the availability of these courses locally enabled more nurses to obtain post-basic qualifications.

A recommendation by the Florence Nightingale Committee of South Africa that a nursing research division be established at SANA was also accepted. This division had to focus on promoting nursing research and training nurses in research work. To promote education and research, the Florence Nightingale Committee of South Africa managed numerous bursaries and grants (DENOSA 1962:20). One example of how SANA's research influenced the development of nursing was its work with the National Institute for Personnel Research to develop tests that would identify suitable nursing candidates. In fact, Miss PA Truscott, who had obtained her BA degree in nursing, was appointed to the Psychometric Division of the National Institute to assist with the research (DENOSA 1962:27).

Another research example is the 1969 research done into the terms of employment of tutorial nursing staff in South Africa. The SANA Board was presented with a seven-page report (DENOSA 1970).

The nurses of South Africa gained access to nursing literature when SANA created educational briefs and manuals and established a nursing library (Radloff 1970a:68). The association also donated money to university libraries in the Cape, Pretoria and the Witwatersrand (Meeting of the Board 1957:11).

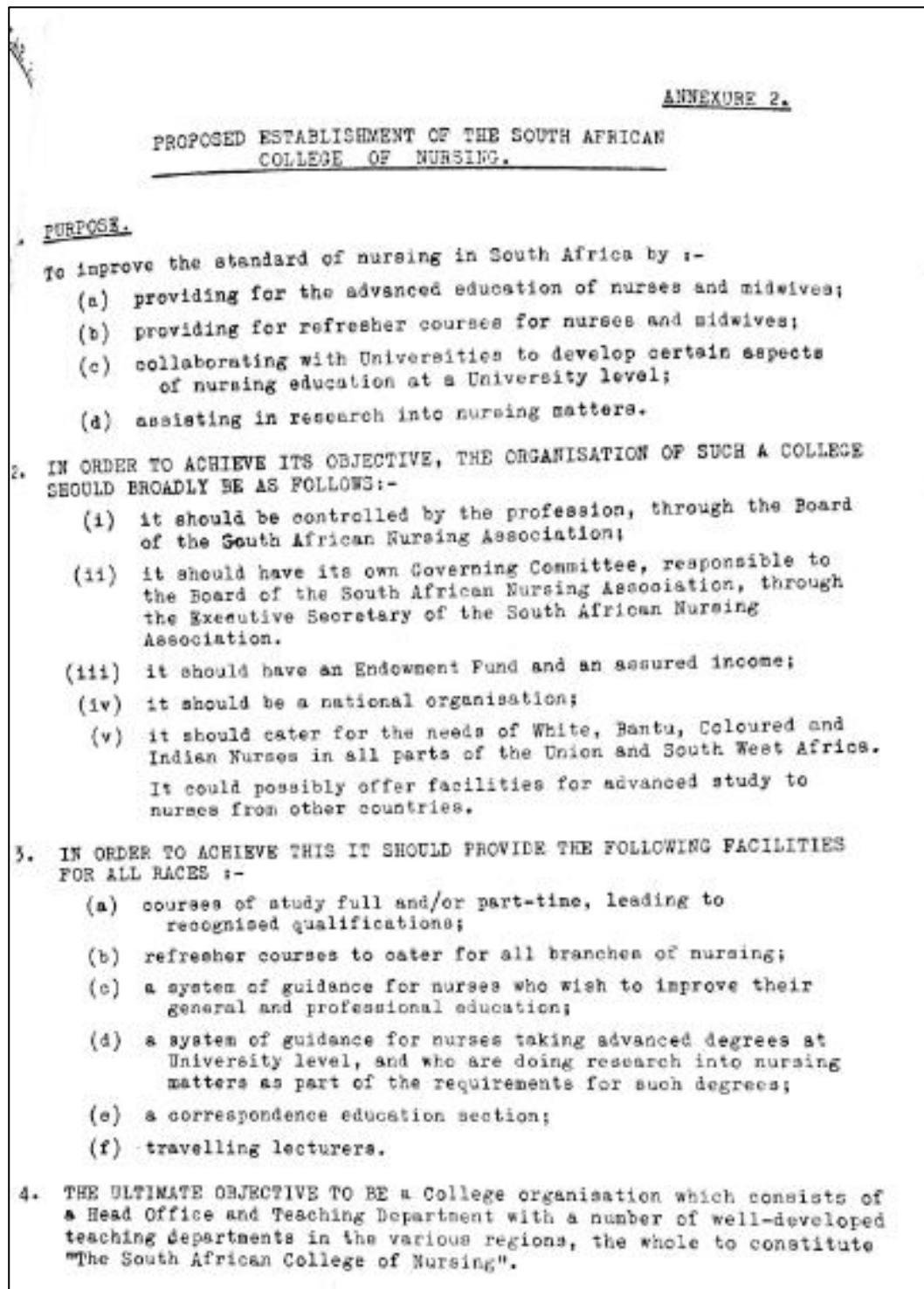


Figure 7.4 Proposal to establish a South African College of Nursing
(DENOSA 1960b)

7.5.2 Nursing services and practice

SANA applied to the International Midwives Organisation for membership, and was accepted as member of the International Hospital Federation (DENOSA 1962:28, 51). This ensured that its members had continued exposure to international trends. The value of attending international conferences became evident when it changed nurses' practice and so influenced the nursing service that patients received. Examples include discussions held about the introduction of disposable syringes in South African hospitals and the standardisation of disinfectant use (DENOSA 1962:54, 67). Nurses were also consulted about equipment used in provincial hospitals; for example, the Inspectress [sic] of Nursing Services served on the Cape Provincial Administration's Committee for Standard Equipment and Supplies (Meeting of the Board 1957:11).

Extensive work was done on the working conditions and functions of health visitors, the needs of its Black members and the working hours of midwives (DENOSA 1962:34, 36, 44; Meeting of the Board 1957:11). SANA also made representations to formal structures such as the Public Service Commission about a reduction in nurses' working hours. In this endeavour, SANA was not very successful, due to the prevailing nursing shortage in the country. Nurses in the 1950s therefore continued to work 50 to 54 hours per week dayshift and 66 hours per week nightshift. It was only in the 1960s that working hours were reduced to 40 to 46 hours per week dayshift and 48 hours per week nightshift (Radloff 1970a:77-79).

7.5.3 Socio-economic welfare

Radloff (1970a:69-77) gives a detailed description of SANA's influence on the economic welfare of nurses. The association made numerous representations to government structures such as the Minister of Health, the Department of Health, Provincial Administrations and hospitals about increased salaries and leave privileges for nurses (e.g. the concepts of study leave and maternity leave were established). She acknowledges that at times the negotiations were successful, while sometimes less so. In 1966, for example, great strides were made with the salaries of White nurses, but not with those of Black nurses. SANA therefore conducted an economic survey to provide its negotiators with information which could inform future salary negotiations.

Another issue that received prompt attention was the question of pension and provident funds. The Superannuation Fund (established in 1930) was an insurance scheme, underwritten by the Colonial Mutual Life Assurance Society Limited, to help nurses plan for financial retirement. Initially African nurses participated in the fund, but Radloff explains that due to “tribal law” (1970a:83) the nurses could not claim the fund money as their own once their policy matured. African nurses’ participation in the fund scheme was therefore put on hold until the issue could be resolved. In 1960, Coloured and Indian nurses were invited to join the scheme, while Black nurses did so from 1962 (Radloff 1970a:83).

The inclusion of married women in the Provincial and State Pension Funds took many years of negotiation. Married women in the Cape and Transvaal provinces were included in 1945–1946. For married women in the Orange Free State and the Natal Province, the wait was longer; they only joined the pension fund in 1957 and 1958 respectively (Radloff 1970a:81).

A professional indemnity scheme was introduced on 1 April 1969, which was valid in South Africa, South West Africa (Namibia), Botswana and Swaziland (DENOSA 1970:10; Radloff 1970a:85-86).

7.5.4 Professionalism

In accordance with a 1960 Congress resolution the SANA Pledge of Service was published in the *South African Nursing Journal* to introduce the profession to its spirit and content (DENOSA 1962:45).

7.5.5 Policy development

The SANA Liaison Committee was in discussion with the Parliamentary Committee of the Federal Council of the Medical Association of South Africa about the nurses’ Scope of Practice and the specialised technical procedures which doctors required nurses to perform. Doctors and nurses had joint responsibility in specific instances (DENOSA 1962:68-69).

Another example of the influence of SANA on nursing practice was the resolutions adopted by the Private Duty Nurses' Discussion Group at the Biennial Congress, which stipulated the rules of conduct for nurses in private practice (Meeting of the Board 1957:12). SANA also had rules (and amended those rules) for the conduct of Discussion Groups (DENOSA 1962:69).

7.6 DEDUCED FROM THE DATA: VULNERABLE INSIGHTS

The years 1944 to the 1970s were dominated by socio-political events and influences. SANA's statutory status position became problematic in the 1950s, when the government formalised its segregationist views into a series of apartheid laws. SANA as a statutory body had to comply with government legislation. Despite its assertions of being a professional organisation only, not involved in political matters, SANA could not distance itself from national and international socio-political events. Locally, splinter groups such as the SANA Witwatersrand non-European Discussion Group, the Federation of SA Nurses and Midwives and Die Afrikaanse Verpleegstersbond illustrated division within the profession – which spilled over and tainted SANA's relationship with the ICN.

SANA's activities from the 1950s to the 1970s must be interpreted against the socio-political influences of the time. The researcher could find no primary documents or letters that prove that the SANA Board actively encouraged segregationist policies. The board did, however, comply with, and never openly challenged, government policy. This is in stark contrast with SATNA engaging in an active campaign to prevent the formation of a trade union in 1942. One explanation for this difference would be that SATNA had government support for its 1942 cause, whereas SANA would have met with fierce resistance if it tried to challenge the government's policies in 1959. Instead, it followed a path of quiet diplomacy, adjusted its professional activities accordingly and defended itself as best it could against its critics. SANA financially assisted its new branches, continued to engage with them and remained in contact with all neighbouring states' nursing associations.

SANA's withdrawal from the ICN was due to a combination of political, ethical and economic factors. The association could not unilaterally change the offensive Nursing Act (69 of 1957); only parliament could amend legislation. The increased cost of ICN membership (due to its new definition of "nurse") and the cost of developing the newly

segregated SANA branches created financial strain. Finally, the suggestion that SANA must oppose its government by means of strike action was ethically unacceptable to the nurse leaders of South Africa. Withdrawing in 1959 would have isolated South African nurses from the international community, but the situation had changed by 1973. SANA had contact with other international health organisations and internally started to create specialist discussion groups. SANA members therefore had continued exposure to research and professional development opportunities.

Despite the socio-political influences of the time, SANA continued to cultivate the professional image of the nursing profession. This is evident in its reluctance to accept nurse auxiliaries as full members of the association and its comments about the loss of professionalism when the ICN redefined its concept of a nurse. SANA continued to campaign for tertiary nurse education, citing scientific development and the expanding role of the nurse. Closely linked with the educational development was the emergence of nurse researchers and published nursing literature. SANA created a system of continued education and professional discussion groups that served to keep its members informed. The call for better educated nurses inevitably required that trained nurses receive better salaries. SANA therefore acted as the watchdog of the profession, the community's needs and its members' economic status.

Figure 7.5 provides a historical timeline that illustrates the significant events that occurred in South Africa, the world at large, and its influence on the development of South Africa's professional nursing organisations.

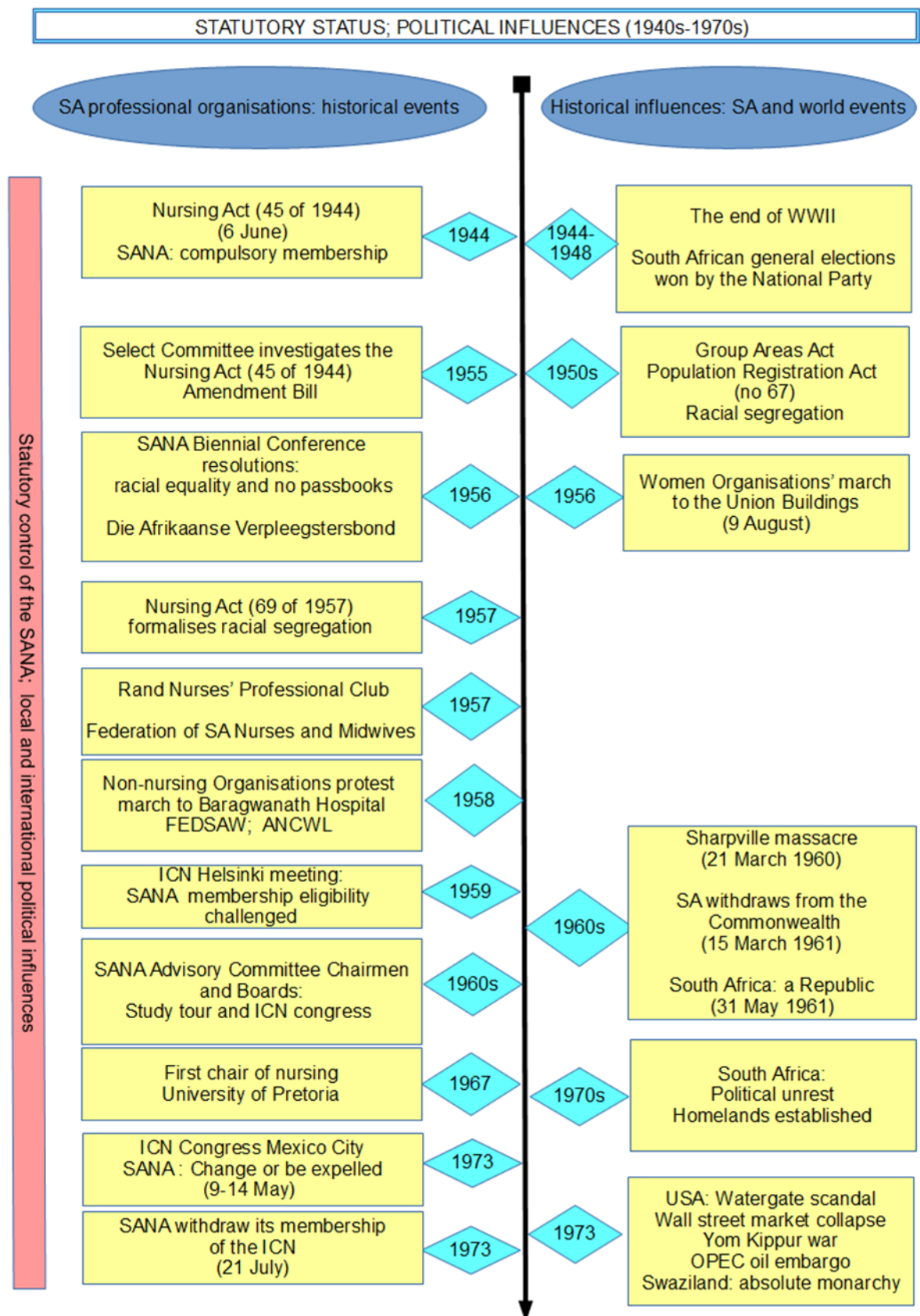


Figure 7.5 SANA in historical context 1940s–1970s

7.7 SUMMARY

This chapter explained how SANA's statutory position made it vulnerable to socio-political influences. South African nursing's only professional association (and therefore the profession) had to comply with the country's apartheid laws. The association could not maintain unity in the profession and splinter groups that objected to SANA's apparent support of government policy emerged. This eventually contributed to SANA withdrawing its membership of the ICN. South African nurses were isolated and without the support of the most influential professional nursing organisation in the world. In the next chapter, SANA's activities as a non-statutory body are discussed. The association's merger with DENOSA will be explained. For the first time in the history of the South African nursing profession, its nurses would be legally introduced to trade unionism.

CHAPTER 8

TRANSFORMATION OF SOUTH AFRICAN NURSING ORGANISATIONS: 1970s–2014

8.1 INTRODUCTION

Chapter 7 discussed SANA's attempts to guide a young profession to professional maturity amid the national and international socio-political events of the 1940s to 1970s. South African nursing was vulnerable to political influence due to its professional association's statutory status, which resulted in the emergence of protest groups such as the FOSANAM and the Rand Nurses' Professional Club.

During the 1980s and 1990s, South Africa's social, political and economic conditions continued to influence the development of the country's professional nursing organisations and consequently the nursing profession. In this chapter the narrative describes how South African nursing organisations worked together through LONASA and how transformation in these professional organisations became possible when the Nursing Act (50 of 1978) was amended. The chapter provides rich, thick descriptions of the transformational processes that led to SANA and the so-called homeland nursing associations merging into DENOSA – a professional organisation with a trade unionist stance. The chapter concludes with a discussion about DENOSA's activities and its influence on the South African nursing profession.

8.2 SOCIAL FACTORS THAT INFLUENCED PROFESSIONAL NURSING ORGANISATIONS IN SOUTH AFRICA

On 2 February 1990, in his opening of Parliament speech, the then President of South Africa, Mr FW de Klerk, lifted the ban on the ANC and other left-wing political parties and announced the release of political prisoners. South Africans were on the brink of a transformational process that would result in a racially integrated society and universal suffrage (Welsh 2000:491; Wood & Harcourt 1998:84-85). The legacy of apartheid had a long-lasting human impact on the nursing profession, in that health care professionals were divided into pro- and anti-establishment factions (Van Rensburg & Benatar

1993:108). Such ideological divisions became evident during South African nurses' endeavours to transform and unite their previously racially segregated profession.

8.2.1 The role of women and nurses in South African society

Although women and nurses gradually gained economic, political and professional independence during the 20th century, they were still a marginalised; subservient group in 1960s to 1990s apartheid South Africa (Gourley 1995:2-3; Möller 2010:61). African nurses occupied a dual social status. Although they were marginalised by the greater South African society as being Black women, in the health-care environment they were regarded as the elite, educated nurses. Black nurses were socialised to follow professional nursing's non-political ideals. Most nurses did not to speak out about the inequalities evident in the health-care system, because the rules of the profession (as laid down by SANC and professed by SANA) and the subservient role of women in society discouraged it (Buch 1990:i; Kedijang & Buch 1990:55, 59-60; Rispel & Schneider 1990:29). They therefore did not question their place in the then authoritarian society, but rather worked within it. Some White women protested the political system, while others tried to assist those oppressed (Möller 2010:61; Uys 1987:55). "Although the Association [SANA] has repeatedly taken a stand against issues such as the fragmentation of health services and the racial discrimination against some of its members, perhaps these protests were put in such a submissive way that they were not even heard" (Uys 1990:76).

8.2.2 Economic and labour relations in South Africa: 1980s to 1994

The Wiehahn Commission, tasked with investigating legislation that governed labour practices in the Departments of Labour and Mines, published its report in 1979. The commission recommended the principle of equal pay for equal work (irrespective of race), that Black trade unions be allowed to register and that job reservation for White persons be abolished. While most of the commission's recommendations were accepted and implemented, the government rejected those which did not suit its political agenda. The Industrial Conciliation Amendment Act (94 of 1979) allowed for the registration of trade unions but prohibited migrant workers (those coming from the so-called homelands) from being members. Furthermore, no multiracial trade unions could register. Many trade unions objected to these stipulations, which eventually led the government to revise the legislation. The Labour Relations Amendment Act (57 of 1981) had no reference to race

and allowed for the registration of multiracial trade unions. Many Black trade unions, however, chose not to register in the 1980s, as the act expected such unions to remain apolitical. By that time, Black South African trade unions were already actively engaged in politics (Liebenberg 1993:469-470; Trade unions, rise of 1989:37-38; Welsh 2000:489-490).

Although some socio-political reforms were allowed, the South African economy and labour remained under tight control (Esterhuysen 1984:12-14; Welsh 2000:479, 489). In the late 1980s and early 1990s (1984 to 1995), political and labour unrest plunged South Africa into an economic crisis. To facilitate negotiations between government, labour and business in South Africa, the National Economic Development and Labour Council (NEDLAC) was established in 1994 (Wood & Harcourt 1998:83-85).

8.2.3 The role of trade unions in South Africa

Union membership increased dramatically over time. In 1955, South Africa had 400 000 union members. By 1993, that number had increased to 2,8 million members (Wood & Harcourt 1998:74-75). In the 1980s, South African trade unions were legal entities during a time when many political parties were banned. Democratically managed trade unions therefore became important enablers of collective opposition against the apartheid government. To create a strong voice which could speak on behalf of the workers, trade union federations such as the COSATU were established. COSATU created democratic structures of control: the workers and their representatives (the shop stewards) mandated union decisions and received regular feedback from their leaders about matters of importance (Buhlungu 2009:91, 94-95, 97-100; Wood & Harcourt 1998:75-76, 81-82). Trade unions' involvement in politics became problematic in the 1990s when South Africa started its democratic journey. Collectivism became less evident, as political decisions were made without consulting the workers (Buhlungu 2009:93,100-103). In the public sector, disagreements between workers and the employer during wage negotiations led to strike action (Wood 2001:146).

During South Africa's transition from an apartheid state to a democratically elected government, trade union federations influenced the new government's economic and social policies. In this COSATU, through the tripartite alliance (with the ANC and the South African Communist Party, the SACP) and its large membership (1,2 million in 2001)

was the most effective. COSATU's influence increased due to its rapid growth in the public sector, yet it was also constrained because some of its members wanted to retain their distinct, recognisable status as professionals (Wood 2001:133, 136; Wood & Harcourt 1998:75). Over time, unions started to negotiate on general issues that were of importance to most of its members (Buhlungu 2009:92).

8.3 PROFESSIONAL NURSING ASSOCIATION OR TRADE UNION?

The Nursing Act (45 of 1944) made South African nursing a closed profession, with compulsory membership of one professional association (Radloff 1970a:33-34; Searle 1982a:44). On the surface South African nurses appeared united, yet many in the profession objected to SANA's compulsory membership and remained inactive in the association (note Chapter 7, sub-section 7.4.3.1). Although they could join trade unions, South African nurses were barred from having trade union representation in the workplace; only SANA could fulfil that role. Therefore, when South Africa itself engaged in a socio-political transformation in the 1980s to 1990s, a fresh debate about SANA membership and trade unionism in nursing gained momentum (Rispel & Buch 1990:62-63). Many nurses thought that SANA was ineffective in dealing with their socio-economic and political needs and believed that trade unionism and other types of organisation in nursing should be discussed (Rispel & Buch 1990:62-63).

Whereas nurses during the 1980s were not considered politically active or vocal (Uys 1987:55), this changed as South Africa's socio-political climate changed (note section 8.2 of this chapter). After working through approximately one hundred *Nursing News* and *Nursing Update* editions dating from 1995 to 2008, the researcher realised that over time articles began to reflect a pro-trade unionist stance. Note, for example, the declaration of the second DENOSA President, Mr Ephraim Mafalo: "Nurses are highly politicised, and they don't take suppression lightly" (Protecting the nursing profession 2004:14).

8.4 A PROFESSIONAL ASSOCIATION: 1970s to 1996

SANA obtained statutory status with the promulgation of the first Nursing Act (45 of 1944) and this status was confirmed in the second Nursing Act (69 of 1957). From 1944 to 1978, SANA's functions and powers were prescribed by law (Uys 1987:55).

The Nursing Act (50 of 1978) was the first in which the functions of SANA were not prescribed. Chapter 5 section 38 of the Act allowed the association to retain compulsory membership and regulate its own affairs (South Africa 1978:35). SANA could write its own constitution, although it still had to be approved by the Minister of Health (Du Preez & Brannigan 1991:39). Section 38 of the Nursing Act (50 of 1978) made it compulsory for all categories of nurses to be members of SANA, which meant that for the first-time nursing auxiliaries became members of the exclusively professional nurses' association (DENOSA 1983b:6; South Africa 1978:34).

8.4.1 SANA and LONASA

The promulgation of the Nursing Act (50 of 1978) occurred at a time when the South African government was establishing the so-called homelands: the independent and self-governing states (Roux 1978:28). This meant that in terms of the Nursing Act (70 of 1982 amended), independent and self-governing states were expected to establish their own nursing councils and professional nursing organisations (SANA 1983:4-5). If nurses started to work in the independent and self-governing states (note sub-section 8.2.2 of this chapter), they were not considered South African citizens and therefore lost their SANC registration (Digby 2012:841; Welsh 2000:450). SANA would have had to relinquish the statutory status that South African nurses had held since 1891 to create one unified professional organisation – something the SANA Central Board chose not to do (Mellish 1990:127; Rispel & Schneider 1990:31-32; Uys 1987:55). Reflecting on SANA's statutory status and the Nursing Act (50 of 1978), Searle (1988:76-77) stated that statutory status implied that the nursing profession accepted the responsibility of self-regulation. She warned that a loss of statutory status would be detrimental as "representation of the profession's interests would pass to a variety of diverse non-professional organisations" (Searle 1988:77).

Several independent and self-governing states established their own professional nursing organisations. SANA appointed Miss DH Radloff to assist with the administrative transition (DENOSA 1983b:3). The first independent state to give statutory recognition to its nurses was the Transkei, with the establishment of the Transkei Nursing Association (TRANA) in 1978. The Ciskei Nursing Association (CINA) was established in 1979 and had its first Central Board meeting in 1980. Also established in 1979 was the Bophuthatswana Nursing Association (BONA), but it had its first Central Board election

only in 1983. The Venda Nursing Association (VENDA) obtained statutory recognition in 1980. Similarly, the Lebowa Nursing Association was formed in 1982. Many of the self-governing states such as Gazankulu, KwaNdebele, Kangwane and QwaQwa also formed professional organisations (Geyer 2006:26). Initially the KwaZulu nurses chose not to establish a nursing organisation (DENOSA 1983b:3). By 1987, the nursing profession in Southern Africa was splintered into various independent associations (Uys 1987:55-56). It was envisioned that these associations would remain in contact with SANA to ensure effective health services throughout Southern Africa (Roux 1978:30).



Figure 8.1 Ciskei nursing commemorative envelope
(Ciskei 1982)

On Saturday 17 April 1982, the President of SANA, Prof Charlotte Searle, met with the SANA Board to start a process already approved by its constitutional congresses and which would culminate in the establishment of the League of Nursing Organisations of Southern Africa (LONASA). The primary objective of LONASA was to create a means through which the various nursing associations in Southern Africa could work together on matters of mutual professional interest (DENOSA 1982b:1-6; DENOSA 1983b:3; Geyer 2006:26). The Pilot Committee met on 30 April 1982 at the then Jan Smuts (now OR Tambo) Airport to deliberate about a constitution for the new organisation (DENOSA 1982c:12). The inaugural meeting of the League was held in Pretoria on Saturday, 30 October 1982. The founder members of LONASA were the nursing associations of

Bophuthatswana, Ciskei, Gazankulu, Lebowa, South Africa (SANA), South West Africa (Namibia), Transkei and Venda. At the first inaugural meeting the League's constitution was ratified and it was decided that member associations would pay 5 cents (equal to R96,94 in 2017) per member per year to belong to LONASA. It was further decided that the Chairperson and Vice-chairperson would change yearly, so that each member association would get a turn (as listed alphabetically) to lead. The first Chairperson of LONASA was Mrs AN Lekgetha from BONA, the Vice-Chairperson was Mrs JV Salayi from the CINA and the Secretary was Mrs EB Ngavirue from Namibia (DENOSA 1983a:1-4; DENOSA 1983b:4).

8.4.2 Influences that necessitated SANA's reorganisation

From 1959 to 1978, the SANA's Central Board and branches' structures consisted exclusively of White, registered nurses. Indian, Black and Coloured nurses (note Chapter 7, sub-section 7.4.2.1) were represented by the three Advisory Boards (Harrison 1982:5). The SANA long-term plan for 1984 to 1988 analysed the association's strengths, risks and the implications thereof (DENOSA 1983c:2-13). In the early 1980s, SANA therefore revised its constitution in response to several internal and external influencing factors that had been identified.

8.4.2.1 External influencing factors

External factors that prompted changes in the SANA constitution were society's opposition to the apartheid system, population growth, South Africa's economic recession, inflation (13%), pressure to reduce or stabilise nursing and medical tariffs and (due to South Africa's 1983 constitution) changes in legislation such as labour laws. These external factors made nurses feel more pressured about training (numbers trained and being informed about the new legislation), posts and their conditions of service (DENOSA 1983c:3-7; South Africa 1980:5). The "workplace became part of the political battle-field" (Uys 1990:72). SANA attempted to remain neutral by stating in point 1.5.3 of its constitution that "neither the Association nor any of its regions, professional societies or branches shall affiliate with any special, cultural, religious, social or political organisation" (SANA [Sa]:1). It did however call on its members to actively participate in professional matters so that the association's negotiation powers could be increased (SANA 1983:6). Critics of SANA state that the association's neutrality discouraged nurses

from speaking out and opposing apartheid's unequal health system. Others believed that nurses' economic and professional survival depended on their complying with the rules (DENOSA 1997:25; Rispel & Schneider 1990:43-44).

8.4.2.2 Internal influencing factors

Internal factors that challenged the status quo included SANA members not paying their membership fees, low voting rates during board elections and inactivity in branch meetings (organisational hierarchy made communication and socialisation difficult). In fact, discussion groups were better attended than branch meetings (DENOSA 1983c:13; Harrison 1982:5; Rispel & Mmatshilo 1988:8). Most important of all was the SANA Board's growing awareness of its members' resolve that the association should develop into a trade union, because this was viewed as the best vehicle with which to negotiate conditions of service. The SANA Board concluded that members did not fully perceive the benefits of being members of a professional association, because the benefits were not tangible and negotiations with employers not professional or skilled enough. Members therefore viewed the yearly subscription increase as a waste of money. Nurses were also pressured at their places of work to join the trade union(s) active in that space.

8.4.2.3 Changes in SANA

The SANA Board resolved to develop the association's negotiation abilities more, so that they could reason from an informed, professional base. To ensure that members were aware of what the association did, its communication with members (e.g. in the *Nursing News*) had to focus on the work being done, the association's plans and its achievements (DENOSA 1983c:7-8, 13, 18-19, 24). Establishing a trade union was not considered. Rather, it was decided to decentralise SANA's organisational structure so that regions could plan their own activities according to their needs. The regions therefore took ownership of their members' professional development, while the Central Board focused on nurses' socio-economic needs (DENOSA 1983c:25; Uys 1990:73).

SANA's first constitution, which became effective on 1 May 1982, made provision for the decentralisation of the organisation and the establishment of multiracial Regional and Central boards (DENOSA 1982a:i; DENOSA 1983b:1; Van Huyssteen 1984:4). The composition of the Central and seven Regional Boards was described using specified

racial ratios, and office bearers were required to be proficient in the two official languages (Afrikaans and English) (SANA [Sa]:8, 16-17). The first multiracial SANA Central Board was elected in 1985. The new board proposed that all reference to race should be removed from the SANA constitution and that branches become integrated, but it was unable to do so due to the socio-political climate in the country and the government's classification of South African citizenship (Searle 1987b:13-14; Uys 1987:55-56). Only South African citizens could serve on SANA Boards, and according to the government that did not include persons living in the self-governing national states (SANA [Sa]:2). The SANA branches thus remained racially segregated. The new constitution made provision for only student nurses, nursing assistants and enrolled nurses to be represented on branch management committees (SANA [Sa]:22, 24). Seven years later, in what Uys (1990:72) describes as "a major shift in a very large and essentially conservative organisation", the 1989 SANA Constitutional Congress removed all reference to race from the association's constitution.

8.4.3 SANA's socio-economic, professional and educational influence

During the 1980s and 1990s, SANA not only spent time on restructuring the association, but its leaders busied themselves with service negotiations on behalf of its professional members and continued efforts to raise nursing education to tertiary education level.

8.4.3.1 Nurses' socio-economic welfare

Given their role as women and nurses in South African society, SANA leaders were on cordial terms with government institutions (note sub-section 8.2.1 of this chapter). In 1970, all three (racially divided) SANA Biennial Congresses called for correction of unjust nurses' salary scales. SANA made representations in this regard to the Public Service Commission, which resulted in two salary adjustments being made in the 1970 to 1971 period, but racial inequality persisted (DENOSA 1972:37-38).

There were occasions where persistence and patience wore thin and nurse leaders made their voices heard. Realising that nurses' conditions of service could be affected by decisions made by the Central Health Services and Hospital Co-ordinating Council, SANA wrote a letter on 30 June 1970 requesting the Minister of Health to grant them representation on the council (Radloff 1970b:1). After numerous letters, follow-ups and

delays, a decision was made on 2 September 1976 to create a committee where SANA and council representatives could discuss a new grading system for nurses. Two years later, the committee had yet to meet – and the Central Health Services and Hospital Co-ordinating Council did not function any more (DENOSA 1978:2; Radloff 1978:1). In a strongly worded memorandum to the Minister of Health and the Minister of Internal Affairs, the President of SANA (Prof Searle) informed the government that nurses of all races and political persuasion were dissatisfied about unfair salary structures, unfair pension benefits, the grading of nursing posts and the unacceptable starting wage of registered nurses. She explained the inequality evident in the salaries of Black nurses and called it “*n skreiende onreg*” (a glaring injustice) (DENOSA 1978:3) that a White student nurse received the same salary as a Black qualified registered nurse. SANA could find no moral justification for that and called for immediate action to address nurses’ issues because they were no longer prepared to be dismissed as “*onbelangrike aanhangsels*” (unimportant appendages) (DENOSA 1978:5).

The association’s membership guide (SANA 1983:7) stated that SANA negotiated on matters of general concern to nurses: on conditions of service, educational matters and about the role and function of the nurse within the health-care team. These negotiations were conducted with SANC, universities, departments of Health and Welfare (and others as needed), as well as with provincial departments and hospital services. An example of such input was the 1984/85 submission to the Commission for Administration. Matters such as annual salary reviews, recognition of qualifications, maternity leave privileges, remuneration for unsocial working hours and improvement in the salary structure of midwives were addressed (DENOSA 1983d:1). In 1988, the SANA Board voted in favour of equality in pay for all nurses, irrespective of race (Brookes 2010:1).

SANA also used statistical analyses to illustrate why registered nurse shortages became evident in the late 1980s, and to motivate its recommendations in that regard. They called for more teaching facilities for Black nurses and training of greater numbers of registered nurses. The association called for the decentralisation and the integration of health services in South Africa (DENOSA 1983e:2-5; Muller 1991:41-48).

8.4.3.2 Female registered nurses' exclusivity safeguarded

It is evident from SANA minutes of meetings that it continued its tradition of ensuring the female registered nurse's exclusivity. In the 1970/71 period, the association submitted recommendations to the Minister of Health for the amendment of the Nursing Act (69 of 1957). One of the recommendations related to the Advisory Committee for Black nurses, who requested an increase in the number serving on the committee. The SANA Board recommended that the number of serving members be increased, but that only registered nurses and midwives could serve on the committee. Nursing students and the sub-categories (enrolled nurses and auxiliary nurses) could vote for a person registered as a nurse and midwife to represent them on the committee (DENOSA 1972:4-5). At SANA congresses students were also not allowed to vote, as they were not considered full members of the organisation, but it was decided to permit them to vote on matters that concerned them (DENOSA 1972:7). Bias against male nurses was also evident. The 8th Biennial Congress for White Nurses called for an end to discrimination against male nurses "except in the fields of gynaecology and midwifery" (DENOSA 1975:30). The SANA Board made representations to SANC, which resolved that male nurses of all categories and those in training "may undertake nursing duties on women and children in out-patients, casualty and clinic services" (DENOSA 1975:30).

8.4.3.3 Contributions to nursing education and research

SANA leaders considered it their duty to bring nurses' training needs to the attention of SANC and to develop nurses into nursing experts and leaders that could serve on the SANC Board (Searle 1988:81). They were further of the opinion that education was at the heart of nursing's relationship with the community it serves.

On 2 March 1982, the Minister of National Education gave approval for a system of co-operation between South African nursing colleges and universities. This approval extended to White nurses only and the SANA Board immediately resolved to make representations that the system of co-operation be extended to non-White nursing education institutions as well as for the establishment of a department of nursing at the University of Durban-Westville (DENOSA 1982c:10, Annexure 1). The reorganisation of the system of training started in 1984 (Kotzé 1985:14). Implementing the system of

nursing education at universities must have been challenging, as Prof Searle likened it to “climbing Mount Everest without oxygen” (Searle 1987d).

SANA’s influence on the development of the nursing profession is best illustrated with statistics from SANC. The supportive, complementary working relationship that existed between the two nursing organisations enabled them to succeed in their goal to improve nursing education in South Africa.

Table 8.1 The historical influence of statutory organisations on nursing education in South Africa

SANA/SANC influence on	Statistics in 1940s	Statistics in 1984
Registered nurses	13 818 (in 1948)	62 345
Basic nursing schools	103 (in 1944)	370
Nursing colleges	1 (in 1945)	37
Universities with basic nursing degrees	zero (in 1944)	14

(Kotzé 1985:11)

8.4.4 Professional discussion groups

Health-care systems all over the world are characterised by diversity in the care required by and rendered to patients. Medical, surgical, trauma and psychiatric patients, pregnant women and children; all require specialised health care. The health-care system must therefore have nurses with specialised knowledge and skills. It stands to reason that these nurses would have a desire to discuss matters of mutual interest with one another. In fact, one of SATNA’s aims had been to hold social and professional gatherings to discuss all matters relating to the interests of the profession (Trained Nurses’ ... 1914b:14).

In South Africa, the first group that specialised in a field of nursing were the midwives. The first locally trained midwives completed their course in August 1813 and the Medical and Pharmacy Act (34 of 1891) made provision for the voluntary registration with the Cape Colonial Medical Council by nurses *and* midwives. Informal training of mental nurses occurred after 1901, while the training of psychiatric nurses only commenced after 1954 (Mellish 1990:120, 125).

At the ICN's 1959 Membership Committee meeting in Helsinki, the admission of national nursing organisations with specialised nurses only was discussed. The SANA President, Miss Borchers, stated that health care was becoming scientific and specialised. Therefore, she argued that the ICN should not consist solely of nursing associations which admitted only generally trained nurses as members. After discussion, the ICN Membership Committee confirmed its decision that future nursing organisations which admitted members with specialised training only would not be eligible for admission to the ICN. At the time of the meeting, South Africa was one of seven countries in the world with a national nursing association which admitted general and specialised nurses (midwives) as members (DENOSA 1959d:7; DENOSA 1959e:1-2).

The influence of the nursing association on the professional development of nurses became evident in the 1950s when the SANA Board asked its discussion groups to each write a paper (to be published in the Biennial Conference souvenir programme) about the role of nurses and midwives in service to the community. There were seven discussion groups involved: Nursing Education and Administration, Midwives, Health Visitors and School Nurses, Occupational Health Nurses, Male Nurses, non-European Nurses and Student Nurses. The SANA Board further recommended to its Biennial Conference that a midwives committee should be formed. The purpose of the committee would have been to advise the board on midwifery-related matters (Board Meeting ... 1956:18-19; Biennial Conference ... 1956:36).

SANA discussion groups facilitated the professional development of nurses by means of offering refresher courses and study courses (DENOSA 1964:6; Harrison 1982:5; Radloff 1970a:91-92). The discussion groups provided an opportunity for nurses to create specific professional identities. Over time, these discussion groups transformed into specialist groups which held meetings, hosted seminars, attended conferences and continued to offer specialist courses. The 1973 *South African Nursing Journal* Index (January to December) lists a total of 22 entries related to specialist groups such as theatre, psychiatric nursing, orthopaedic and paediatric nursing (University Free State 1973e:8-9). Such specialist discussions and published research papers were evidence of nurses' professional maturation (Harrison 1982:5). As part of its reorganisation strategy in the 1980s, SANA continued to promote specialist groups and discussion groups at branch level. Specialist groups transformed into professional societies which could apply to SANA for recognition as a National Professional Society (DENOSA 1983c:25;

Ngwanya 1982:1; Uys 1990:71-72). By 1983, SANA had professional societies active in the fields of occupational health, midwifery, theatre, curriculum development, psychiatric nursing, stoma therapy and renal care (SANA 1983:15). The curriculum development group transformed into the Nursing Education Association (NEA 2018).

It is beyond the scope of the thesis to provide an in-depth description of all the specialist nursing societies (historical and current) that contributed to the professional development of South African nursing. The table below lists a few of the diverse discussion groups and nursing societies that, with the support of SANA and later DENOSA, contributed to nurses' professional development. Note how in later years titles indicate formal societies. Regional nursing societies transformed into national (South African) societies, which in turn affiliated with international organisations. In this way, South African nursing organisations assisted the professional development of nursing by creating a national and international network of expertise and support.

Table 8.2 Examples of how South African nursing discussion groups transformed into a national and international network of expertise and support

Discussion group/Professional society	Established	Reference/Source
Coloured Midwives Discussion Group	±1970s	Venter 1978:26; Curationis 1(1)
Transvaal Infection Control Society	1975	Nursing News June 1995 19(6):35 http://www.gics.org.za/
National Society of South African Theatre Sisters (SATS)	SATS Journal 1976	Nursing News October 1995 19(10):11
Nursing Education Association (NEA)	1980	http://www.edunurse.co.za/Member
OVS Operasiesaal Besprekingsgroep	±1983	DENOSA 1983b:11
OVS Black Nurses' Multidisciplinary Discussion Group	±1983	DENOSA 1983b:11
SANA specialist societies	±1983	SANA 1983:15
East, Central and Southern Africa College of Nursing (ECSACON)	1990	Nursing Update October 2002 26(9):14-21 http://ecsacon.org/
Forum for University Nursing Deans in South Africa (FUNDISA)	1994	Nursing Update Oct 2000 24(10):8
Nursing Managers' Forum	[Sa]	Nursing News July 1995 19(7):7
Forum of Professional Nurse Leaders (FPNL)	1996	Nursing Update Oct 2000 24(10):1 https://fpnl.co.za/
Society of Private Nursing Practitioners	e-mail	Nursing News Nov 1997 21(11):11
Southern African Development Community AIDS Network of Nurses and Midwives (SANNAM)	2001	Nursing Update Dec 2001/Jan 2002 25(12):4
South African Neonatal Association (SANA)	2004	Nursing Update July 2004 28(6):10-12
Society of Midwives of SA	2009	Nursing Update July 2004 28(6):10-12 Monteiro 2018

Although Searle (1987a:141-142) supported the development of specialised societies, she was concerned that these sub-groups might break away from the parent organisation, thus weakening its ability to be the unified voice of the profession in socio-economic negotiations. She suggested that sub-groups remain linked with the parent organisation by forming affiliations or federations.

8.5 PROFESSIONALISM, IMAGE AND EXCLUSIVITY

Since the late 19th century, British and South African nurse leaders had striven to elevate nursing from a task being performed by the uneducated to a profession for the educated (mainly women). In South Africa, their efforts resulted in the establishment of a closed profession: only those who trained, qualified and registered with SANC *and* were members of SANA could practise the art of nursing (note Chapters 4–7). Professional associations greatly contributed to the development of South African nursing. By the end of the 20th century, it complied with the criteria of a profession. Yet, it is impossible to ignore the fact that some felt the exclusivity of professionalism came at a cost to society (too few nurses trained) and to the profession itself (socio-economic needs were not prioritised). This ambiguity about professionalism and its influence on South African nursing lies at the heart of the debate about the type of professional organisation that would best serve the needs of nurses and promote the professional development of nursing.

8.5.1 The argument for professionalism and a professional association

Those South African nurses in support of having a nursing association would possibly declare that the development of a trained nurse with a strong ethical foundation of practice was the SANTA's and SANA's greatest legacy. Over a period of 82 years (1914 to 1996), the two associations directed the socialisation of South African nurses towards a professionalism characterised by education, ethical behaviour and exclusivity. In the first edition of SANA's scientific journal, the *Curationis*, Prof Charlotte Searle, President of SANA for 10 years (1973-1983), stated that professionalism was about knowledge, wisdom and "great moral certitude" (Searle 1978:5). She considered professional associations as a fundamental necessity that would enable the development of a profession. She averred that a profession was recognised by the presence of four crucial criteria: a form of licensing and registration; formal tertiary education; disciplinary control by one's peers; and a strong professional association. While SANC exerted disciplinary control, the professional association was tasked with keeping the philosophy of the profession alive (Searle 1987a:117, 137, 145). An active professional association was the "seed bed in which ... leadership potential is nurtured ..." (Searle 1987a:145).

Other nurse leaders and authors confirm that professional associations developed nursing and nurses whilst protecting society (Du Preez & Brannigan 1991:33-34). “E[e]very profession should rest upon a professional base of service to the community, a body of knowledge and adherence to a code of ethics” (Nzimande 1987:20). It was therefore essential that most practising nurses attain an elevated level of professionalism (Kotzé 1987:31). The debate about nursing being a profession would end if the professional association was disregarded (Pera & Van Niekerk 1994:iv).

Conservative nurse leaders accepted that professions exert political influence (Mellish 1990:133; Searle 1987a:122), but differed from trade unionists, who supported nurses’ right to strike. SANA leaders believed that the patient (society) should never be used as a bargaining tool and that the nurse-patient relationship would be harmed by nurses going on strike, leaving patients vulnerable (Searle 1987a:140-141; Searle 1988:151). SANA’s position paper on the responsibility of the professional nurse in times of civil unrest confirmed this view (Position paper ... 1987:40). In later years, DENOSA’s draft policy on essential services recognised nurses’ right to strike but reiterated the patients’ right to safe health care (DENOSA draft ... 1998:13-14; Mngomezulu 2004:50).

8.5.2 Criticism of professionalism; pro-trade unionism

Rispel and Schneider (1990:25-34) state that professionalism benefited nursing and society in that it developed standards of care that benefited the patient. The system also benefited some nurses (e.g. the registered nurse) because they gained the right to practice independently. However, nurses negated their social responsibility to speak up about the socio-political ills that surrounded them. To remain in a position of privilege, an elitist group of nurses encouraged professional neutrality, which meant that South African nursing did not oppose the social inequality of the apartheid era’s health-care system. Professionalisation was therefore considered to be an expression of “professional arrogance” by an elitist group which used its skills and knowledge to monopolise opportunities and privileges. It was a means of separating themselves from the working class (Hull 2010:853; Mditshwa 1990:80; Rispel & Schneider 1990:20-21, 39-45). This view is echoed in a speech delivered by the DENOSA President, Mr Ephraim Mafalo: “Nursing is a profession, ... but does not qualify the description of being a ‘calling’ in a politically dynamic country like South Africa”; referring to nursing as a calling is “the exploitation of the working-class nurses” (Protecting the nursing profession 2004:14).

8.6 THE SANA AND DENOSA MERGER

Although this section refers to other nursing organisations in Southern Africa, the focus of the discussion remains on the two largest, most influential nursing organisations: SANA and DENOSA. The merger of a purely professional nursing association (SANA) with a professional nursing organisation which had a trade union section (DENOSA) is described. Added to the discussion is a time line that summarises the historical events (note Table 8.3).

8.6.1 The time is right for change: 1987 to 1993

The SANA Board initiated talks in 1987 which eventually resulted in the 1992 amendment of the Nursing Act (50 of 1978). In November 1988, the multiracial SANA Board proposed that the association's constitution be changed to remove all reference to race and to make nurses working in the independent and self-governing states eligible for election on regional boards (DENOSA 1995b: annexure B; Lubanga 1991:75).

The debate about compulsory membership and the closed-shop principle in nursing came to the fore again. About giving up the negotiation power brought about by the closed-shop principle, Uys (1990:75) concludes that "if the profession gives up this privilege, there is almost no chance at all of ever getting it back". It was acknowledged that the closed-shop principle strengthened nurses at the negotiation table – but ironically it also weakened their position. Employers familiar with SANA's non-trade-unionist stance possibly felt comfortable in the knowledge that nurses would not resort to industrial action such as striking en masse (Uys 1990:74-75). To strengthen its position, SANA therefore had to consider trade-union-like mechanisms such as collective bargaining, which it introduced for nurses working in the private health-care sector. In the public sector, which employed approximately 50% of South Africa's registered and enrolled nurses (Bruwer 1993:2), SANA strove to become a staff association recognised by the Commission for Administration. It used its influence as the largest nursing association in the country to effectively block the proposed amendments to the Public Service Act that was set to go to Parliament in 1989 because SANA was not included when it was decided (Uys 1990:72-73, 78).

It became clear that SANA, which until this point had focused primarily on establishing the professional nurses' image, promoting tertiary nursing education and improving nurses' socio-economic welfare, had to reconsider its priorities due to the socio-political changes evident in South African society (Bruwer 1993:1; Du Preez & Brannigan 1991:40, 42, 50). It was time for the fragmented nursing profession to "act in harmony" (Bruwer 1993:1). Organised by the Concerned Nurses of South Africa (CONSA), the first National Consultative Conference was held at the Lionsdale Hotel in Durban from 12-14 February 1993. The keynote address was delivered by Mrs Albertina Sisulu. Other speakers at the conference included international speakers from Zimbabwe and Kenya, the US National League for Nursing, the President of the Service Employee International Union and COSATU National Organiser, Mr Zwelinzima Vavi (Concerned Nurses...1993; Mafalo 2002:10). At the time of the first National Consultative Conference, South African nursing was recognised for its nursing standards and the profession's participation in the tertiary education system. Yet nurses were seldom consulted regarding South Africa's health care plans, in part due to paternalism. Internally the profession struggled with issues such as the legacy of apartheid, which splintered nurses (and the health-care system) along racial and cultural lines. Furthermore, the nursing profession was at odds about the politicisation of the profession (Bruwer 1993:3-5). The conservatives maintained that nurses should remain neutral, as SANA attempted to do, while activists believed that nurses should speak up about injustices and inequality in health-care matters (note section 8.4 of this chapter).

8.6.2 The Nurses' Forum

Despite their differences, nurses at the first National Consultative Conference agreed to establish a nurses' forum "to formulate a vision for the nursing profession in Southern Africa that will lead to a planning process for change in order to meet the future needs and challenges of the profession" (Nurses Forum 1993a:1). The steering committee met for the first time on 24 February 1993. It decided that only nurses would be members of the committee, and that two representatives of each participating nursing organisation would serve on the committee. The nursing organisations that were represented on the steering committee were BONA, the KwaZulu Nursing Association (KNO), TRANA, the CINA, the Namibia Nursing Association (NNA), VENDA and SANA. The forum elected Professor PN Nzimande as its facilitator and Dr A. Joubert as its secretary (Mafalo 2004:11; Nurses Forum 1993a:1-4). At the second meeting, it was confirmed that the

criterion for participation in the steering committee was all categories of nurses and nursing organisations (not individuals) that represented nurses/nursing. More organisations, namely the CONSA, the Democratic Association of South African Nurses (DASAN), the Qwa-Qwa Nursing Association, Nurses in Kangwane and trade unions involved in nursing were invited to participate (Nurses Forum 1993b). The forum chose an *ad hoc* committee to organise a convention where the nurses of South Africa could give their input regarding the future organisation of the profession (SANA 1993:1-2).

The position in which South African nursing found itself was complex. Not only had the nursing profession to find common ground on which to unite numerous professional organisations, but it had to deal with SANA's statutory status, its elections due in 1994 and the professional activities that the association was engaged in on behalf of its members. The Nurses Forum requested SANA to not elect a new board (the then current board's term of office ended 30 September 1994) and to not request any amendments to the Nursing Act (50 of 1978) during the transitional discussions (Geyer 2006:28; Nzimande 1993). The Nurses Forum was made aware of the urgency of the nursing profession's being represented on the National Health Forum. This was the forum where South Africa's new health dispensation was being discussed. It was essential that nurses have a voice about where nursing would be placed within this forum. SANA and SANC had drawn up a provisional discussion document (another example of the working relationship between the nursing association and the governing body) and offered it for use by the Nurses Forum. The Nurse Forum decided to formally contact the National Health Forum's chairpersons and ask that it be represented. In preparation it chose two representatives, Prof Rachel Gumbi (Transkei) and the then Miss Sarie Human (SANA) tasked with representing South African nursing and discussing nursing issues (SANA 1993:2-3).

8.6.3 The Transitional Nurses' Committee

The first National Convention of Nurses of South Africa was held from 28-30 January 1994. The welcoming speech was delivered by Mrs Albertina Sisulu, while the opening address was delivered by Prof Philda Nzimande. Over the three days of the convention, the nurses of South Africa deliberated about their future. Discussions were focused on nurses' concerns and the democratisation of the profession, the organisation and regulation of nurses and nursing, industrial relations, health-care systems and services,

as well as nursing education. On the last day of the convention, a temporary structure that would lead the profession's transformation, the Transitional Nurses' Committee (TNC), was formed (Geyer 2006:28; Nurses Planning ... 1994:1-2).

The TNC held its first meeting from 24-25 February 1994 (Geyer 2006:28-29) under the chairmanship of Prof Nzimande. The Vice-Chairman was Miss T Gwagwa and the Secretary Professor L Uys. Eleven working groups were established to facilitate the TNC's aim to transform South African nursing organisations and the nursing councils. To this end, the TNC planned a congress to debate a draft constitution and elect an interim national board (About the TNC [Sa]; Transitional Nurses committee 1994a). As work progressed, more nursing organisations joined the TNC's activities, but there were those who felt that bedside nurses were left out. Nurses from the Pretoria, Witwatersrand and Vereeniging region were therefore invited as observers. (Transitional Nurses Committee 1994b:6, 8). South African nurses were also invited to give written submissions for the draft constitution. A total of 67 individuals and nursing groups responded. The TNC committee that formulated the draft constitution included registered nurses, enrolled nurses, auxiliary nurses and students. From 25-27 July 1994, 18 nurses representing all provinces (excluding the Free State and the Northern Cape, who were unable to attend) worked through the input received to draw up the draft constitution. Of the 18 nurses, 15 were registered nurses and three were sub category nurses. There were six nurse educators, four nursing administrators and eight clinical nurses on the committee (Transitional Nurses Committee 1994b:4; Uys 1994:1-3). The draft constitution, attached to a letter sent by the chairperson of the Constitutional Working Group, Prof Liana Uys, suggested three basic models for a future nursing organisation: firstly, a labour union with limited/wider functions; secondly an organisation with a labour union section and a non-labour union section; and thirdly a purely professional organisation. The option most evident from South African nurses' submissions was the second: an organisation with a labour union section and a non-labour union section (Uys 1994:2, annexure).

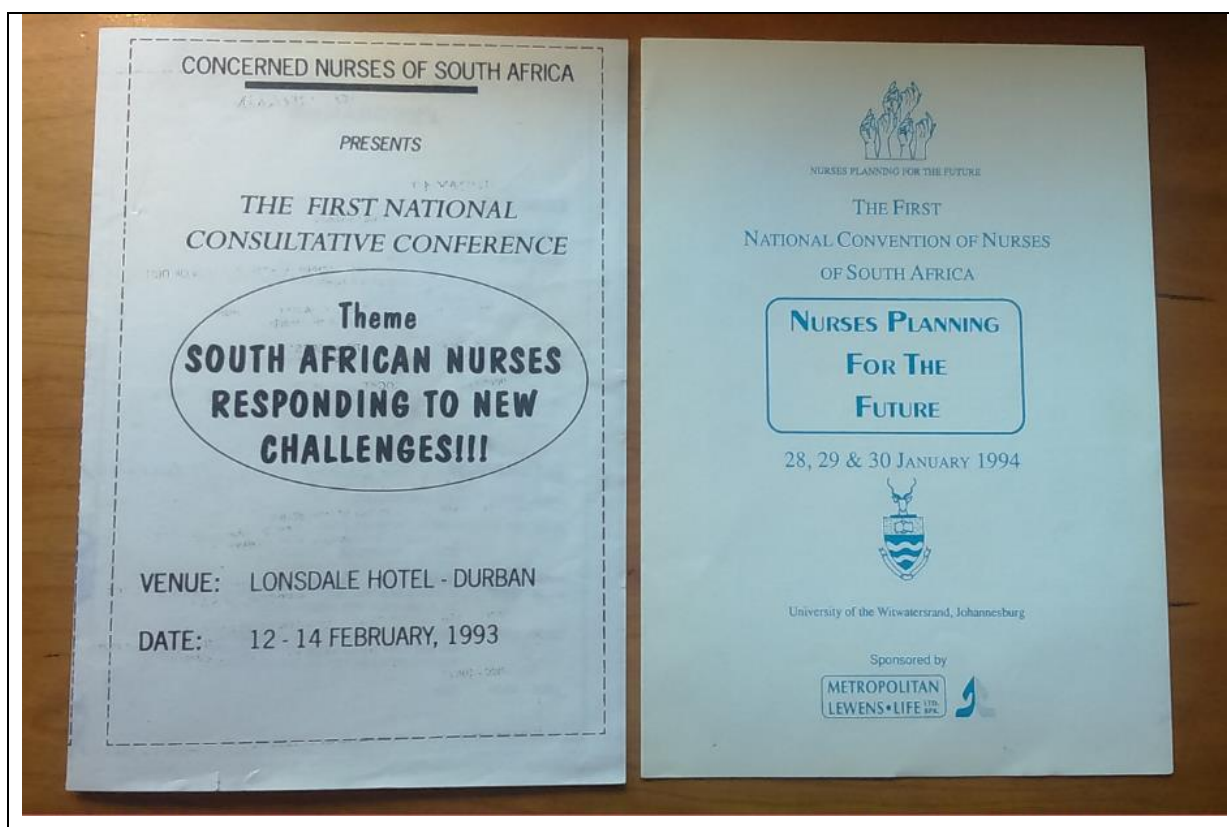


Figure 8.2 Programmes of the First National Consultative Conference and the First National Convention of Nurses of South Africa

(Concerned Nurses ... 1993; Nurses Planning ... 1994)

8.6.4 SANA and DENOSA negotiations: 1995 to 1996

The draft constitution created by the TNC's Constitutional working group was debated and adopted by 680 delegates at a Constitutional Conference held from 26-28 January 1995 at the Synodal Centre in Pretoria. Most delegates voted for the establishment of a professional organisation with a trade union section. The nurses of South Africa were the first to hold such a constitutional conference to unite their profession (New democratic organization ... 1995:2; Geyer 2006:28-29).

A new professional organisation, DENOSA, was established and the work of the TNC came to an end. Each province had to hold meetings before 18 February 1995 to elect three representatives to serve on the INB which would initially lead the new organisation (DENOSA 1995a:1; Transitional Nurses Committee 1995:1). There was severe criticism of the brief time (three weeks) given to elect the INB (e.g. it was difficult to communicate voting dates and find suitable venues) and about proxy votes not being allowed. Nurses who lived far from their branches and those on duty were unable to participate in the

voting process. The result was that a low percentage of nurses voted. The INB met for the first time on 11 March 1995 under the chairmanship of Prof Philda Nzimande and Vice-Chairmanship of Prof Marie Muller (Elections of ... 1995:4).

8.6.4.1 SANA plan to dissolve

The SANA Board wrote a letter to its members explaining the outcome of the January 1995 Constitutional Conference and asked them to vote in support of negotiations with the DENOSA Interim Board. Only 293 SANA members voted against negotiation with the new organisation, stating that they feared a nurses' union embroiled in politics and the effect of strike action on the professional image of nursing. But as in previous referendums, most SANA members did not vote (DENOSA 1995a:1-2; SA Nursing ... 1995:4). The first meeting between the SANA and DENOSA negotiation teams was held on 24 April 1995 (DENOSA 1995b:1-2) and, based on the assumption that SANA would dissolve, signed an agreement on 15 June 1995 (It is time...1995:4). Aware that the transfer of SANA assets to DENOSA would incur transfer duty (tax), the SANA Board wrote to the Minister of Finance and the Commissioner of Inland Revenue requesting exemption from transfer duty. Permission was denied, but the Commissioner of Inland Revenue and the attorneys involved suggested an alternative. If SANA and DENOSA merged, no transfer duty would be payable because SANA would have merely changed its name, SANA constitution would become obsolete and the DENOSA constitution could be adopted. SANA as a legal entity would not be affected because it was only the name of the organisation and its constitution that had changed. SANA's assets and its membership would be transferred to DENOSA. Although the advice was financially sound, DENOSA was not willing to accept the proposal, as it would create the impression that the new organisation was simply a continuation of the old association, although with a different name and a new constitution. The new organisation's credibility would be compromised (DENOSA 1995d:1-2; DENOSA 1995e:1). SANA sent several proposals to DENOSA and received a counter proposal from the new organisation that suggested a change to the 15 June 1995 agreement: the two organisations must apply for transfer duty exemption together. If that was not successful, negotiations about the payment of transfer duty would be renewed. The SANA Board accepted DENOSA's proposal that they together apply for transfer duty exemption (DENOSA 1995e:1).

The SANA Central Board recommended the dissolution of SANA because they believed that South African nursing needed one united nursing organisation that would have greater bargaining power. Another reason also emerged for the SANA Board's communication with its regional structures: "The Central Board sincerely believes that if SANA does not dissolve and attempts to continue to function, it will be politically marginalised and become a small fringe organisation with insecure prospects. Even at this moment, SANA is not invited to sit on important commissions and attend important meetings, as it used to be in the past" (DENOSA 1995c:1). The board assured SANA members that the agreement with DENOSA was in the best interests of South African nurses and professional nursing. SANA members were asked to vote on 17 October 1995 at 17:00 in favour of dissolution of the 50-year-old association. The association's constitution stipulated that 75% of its branches must vote in favour of dissolution. If a majority vote was not obtained, SANA would have to hold a constitutional congress (DENOSA 1995c:1; It is time ... 1995:1-4; SAVV 1995:1-3). This all-important SANA referendum coincided with a public service nurses' strike (Nurses' Strike 1995:4-6).

8.6.4.2 SANA branches vote against dissolving the association

The SANA Central Board did not receive the 75% majority vote it needed to dissolve the association. SANA therefore requested a meeting with DENOSA on 2 November 1993 and called a national meeting of SANA delegates for 3 November 1995 (Brannigan 1995a; DENOSA 1995h:1; SANA 1995:1). DENOSA expressed its disappointment at the outcome of SANA branches' vote. The new organisation had two options: challenge the results of SANA referendum and create a divide in South African nursing; or find alternative ways (e.g. a merger) to unite the profession. The nursing profession's transitional process reached an impasse. The 15 July 1995 agreement depended on SANA's dissolution. The SANA branches' vote against dissolution made that agreement invalid. Neither DENOSA nor SANA had a mandate to respond to the situation and SANA's statutory status required them to obtain legal advice (DENOSA 1995f:1-2).

At the national meeting of the SANA management structures (3 November 1995), the President of the Association, Prof ME Muller, explained that the results of the referendum meant that SANA could not be dissolved. She stressed that the branches of the association must continue to function to facilitate further decision-making. She confirmed that the unification of the South African nursing profession remained the primary goal,

that a merger with DENOSA was suggested and that the SANA Board was awaiting the new organisation's decision in that regard. However, the SANA constitution only made provision for dissolution and not for a merger. The board therefore did not have a mandate from its branches to merge with another organisation. The SANA Board proposed that the constitution be amended to allow for a merger and that the board be given a mandate to negotiate a merger with another professional organisation. The Board's proposal was accepted by 124 votes, while nine voted against it and two abstained (DENOSA 1995g:3). The proposals agreed upon by the delegates at the national SANA meeting were sent to the association's branches requesting their mandate by the end of January 1996 (Brannigan 1995b:1-3; DENOSA 1995g:1-3; DENOSA 1995h:1-3).

8.6.4.3 Negotiations towards a merger with DENOSA

On 23 November 1995, SANA and DENOSA signed a second memorandum of agreement: the process of transforming South African nursing must continue. Since SANA could not dissolve, other avenues to achieve unity had to be explored. Both organisations agreed to engage with their membership, identify such alternatives and give each other feedback by the end of January 1996 (DENOSA 1995i:1-2).

As requested by its Central Board, the SANA branches voted in favour of inserting a merger clause in the association's constitution (DENOSA 1996a:1). The branches also mandated the Central Board to continue with a "merger/unification process with any organisation/s with same or similar objects and philosophies as the Association" (Brannigan 1996a:1). The phrasing of the SANA branches' mandate caused some unease in DENOSA, because it implied that SANA could consider a merger with nursing organisations other than with the new nursing organisation. DENOSA suggested the "re-opening of nominations for elections to allow for inclusiveness" (Gwagwa 1996:1) followed by elections. The organisation also confirmed its commitment to deal with issues that might delay the unification progress (Gwagwa 1996:2).

The negotiations for a merger were possibly one of the most challenging periods for SANA and DENOSA nurse leaders. Their agreement signed on 15 June 1995 was based on SANA's dissolving. A merger implied that a new agreement had to be negotiated. The three most contentious issues were the constitution, the name of the merged organisation and the future employment of SANA's permanent staff. Constitutionally it was proposed

that the new merged organisation should have professional association and trade union sections. At the behest of some of its branches and regional boards, SANA proposed that a referendum be held to choose a name for the merged organisation. The association was concerned that many of its members would leave a merged organisation called DENOSA. A new nonaligned name (not necessarily SANA or DENOSA) might be beneficial. DENOSA disagreed and believed that the name of the new organisation had been accepted by the Constitutional Convention (26-28 January 1995) and that it signified South Africa and its nursing profession's new era of democracy (DENOSA 1996c:3-4; Nzimande 1996:4; SANA 1996a:2-5, annexure B). Negotiations reached a deadlock. The SANA provincial structures were asked for a mandate to break the deadlock by opting for mediation, but not arbitration. South African nurses themselves had to decide about the future of the profession (DENOSA 1996b:1-3; DENOSA 1996c:1-2). The DENOSA negotiation team also believed that discussions about the nursing profession should remain in the hands of nurses, but expressed its "serious reservations" (Nzimande 1996:2) about SANA's commitment to unification.

The researcher deduces that the two nursing organisations were negotiating from different viewpoints. Philosophically, both organisations supported the unification of South African nursing. DENOSA had a strong ideological motivation; it was gaining members and socio-political power, but as a new organisation was financially weak. SANA approached negotiations from a corporate (as a legal entity) point of view: financially the association was sound, but it stood to lose members and socio-political power. As a corporate body, it had deadlines and urgent administrative matters to attend to (such as sending out accounts to ensure an income for the next fiscal year and preparing information to be published in the *Nursing News*) and urged DENOSA to inform the SANA Board whether the negotiations for unification were on or off by 2 September 1996 at 10h00. DENOSA was also requested to commit to a joint management committee meeting on 7 September 1996 (Brannigan 1996b:1-2) to conclude negotiations.

8.6.4.4 SANA and DENOSA merge

On 9 September 1996, SANA and DENOSA released a joint media statement that announced the merger of the two South African nursing organisations. From 1 October 1996, the interim name of the new nursing organisation would be DENOSA. It was agreed that the organisation's name would be finalised at a national congress convened before

31 October 1997. SANA members automatically became members of DENOSA (DENOSA 1996d:1; Muller 1996:1). The agreement between the two organisations, formally signed on 26 September 1996, stipulated that the unification process would occur in two phases, namely to unify in a Joint National Board, and later to restructure the profession under leadership of a new National Board. It further stipulated that (SANA 1996b:2, 5-7, 11, 16-17):

- “The new organisation shall have trade union and professional functions.
- To further unify the profession, DENOSA will continue to negotiate with other nursing organisations which have not yet dissolved.
- The SANA Central Board will encourage the professional societies affiliated with it to continue their affiliation with DENOSA.
- The *Nursing News* will be the interim information source.
- The Institute for Professional Development will continue, but the National Board will review, amend and add content as required.
- SANA members become DENOSA members unless otherwise stated by the individual member.
- In choosing the name of the new organisation, the “SANA” would not be on the list of possibilities.
- The existing SANA head office (in Church Street, Pretoria) will not be disposed of as long as the unified organisation (DENOSA) exists.”

The SANA Central Board held a farewell dinner on 3 October 1996 (SANA 1996c). The next evening, on 4 October, the INB and Central Board members attended a special, celebratory dinner. The first Joint National Board meeting was held on 5 October 1996 (Gwagwa & Brannigan 1996:1). DENOSA was officially launched by President Nelson Mandela on 5 December 1996 (DENOSA 1996e; Message by President ... 1997:4). He referred to the negative, divisive impact that the past political system had had on South African nurses and called on the profession to assist with the transformation of the country’s national health system. DENOSA should become the agent of change needed (Message by President ... 1997:4).

Table 8.3 Timeline of transformation in South African nursing's professional organisations

Transformation in South African nursing's professional organisations: 1987 to 2001		
Date	Leading organisation(s)	Influencing events
1987	SANA	Initiated talks resulting in 1992 amendments to Nursing Act: National State nurses could become SANA members (if agreed by their governments).
1989	SANA	Changed constitution to remove all reference to race; accepted principle of collective bargaining.
12-14 Feb 1993	Concerned Nurses of South Africa	1 st National Consultative Congress.
24 Feb 1993	Nurses Forum	Meeting to form the Nurses Forum steering committee. Eight nursing associations involved.
14 March 1993	Nurses Forum Provincial Steering Committee	Meeting set criteria for participation. Identified additional nursing organisations that might join. Created letterhead and slogan: "Nurses Planning for the Future".
3 Sept 1993	Nurses Planning for the Future Forum (NPFF)	Ad-hoc committee selected to organise a national nursing convention to discuss a future nursing organisation. A committee established to create a vision for the NPFF.
28-30 Jan 1994	Nurses Planning for the Future Forum (NPFF)	1 st National Convention of Nurses of South Africa. A temporary body established to lead the envisioned transformation of SANA, other nursing organisations and councils.
24-25 Feb 1994	Transitional Nursing Committee (TNC) under Chairmanship of Prof PN Nzimande	1 st meeting. The TNC was tasked with the formulation of a draft constitution for new nursing organisation and planning a congress to debate it.
26-28 April 1994: <i>South Africa's first democratic national elections</i>		
April-July 1994	Transitional Nursing Committee (TNC)	67 individual and groups of nurses sent input for draft constitution to TNC.

Transformation in South African nursing's professional organisations: 1987 to 2001		
Date	Leading organisation(s)	Influencing events
23-24 Jun 1994	Transitional Nursing Committee (TNC)	Five new nursing organisations joined TNC.
25-27 Jul 1994	Transitional Nursing Committee (TNC): Constitutional working group under chairmanship of Prof LR Uys	Constitutional working group and provincial representatives drafted constitution. The 18 nurses included all three nurse categories. Specialities represented: education, clinical and administrative.
28-29 Jul 1994	TNC Constitutional working group	Draft constitution presented to TNC. Once approved: sent to provinces for debate.
26-28 Jan 1995	Transitional Nursing Committee (TNC)	National Constitutional Congress held: New constitution adopted. New nursing organisation established. DENOSA (±7000 of ± 180000 nurses). Interim National Board (INB) to be elected (within 3 weeks) with three persons from each province.
10 March 1995	Transitional Nursing Committee (TNC)	TNC activities ended.
11 March 1995	DENOSA Interim National Board	First meeting of INB.
24 April 1995	SANA & DENOSA under co-chairmanship of Prof M Muller and Prof PN Nzimande	First meeting between SANA and DENOSA to initiate negotiations.
15 June 1995	SANA & DENOSA	Negotiations completed, and agreement reached.
21 July 1995	SANA Circular to Regional Board members	Central Board supported SANA dissolution; asked branches to vote.
16 Aug 1995	SANA & DENOSA	SANA to transfer assets to DENOSA. Minister of Finance: no exemption on transfer duties. DENOSA opposed to a merger, which would make transfer duties redundant: Potential deadlock. Agreement of 15 June 1995 amended: responsibilities re transfer duties to be negotiated. Ownership of all assets to DENOSA.
17 Oct 1995	SANA	SANA branches voted on the association's dissolution (75% majority in support required).

Transformation in South African nursing's professional organisations: 1987 to 2001		
Date	Leading organisation(s)	Influencing events
18 Oct 1995	SANA	63 of 85 SANA branches voted <i>against</i> dissolution of the association. SANA suggested urgent meeting with DENOSA on 2 Nov 1995. SANA organised national meeting of delegates on 3 Nov 1995.
2 Nov 1995	SANA & DENOSA	The 15 June 1995 agreement was based on SANA dissolution. SANA branches opposed dissolution; therefore, agreement not valid. Two options remained: (1) DENOSA challenge referendum results and split the profession. (2) SANA & DENOSA find an alternative e.g. a merger. Neither organisation had a mandate to respond.
3 Nov 1995	SANA National meeting	The objective remains unification of the profession. Consider alternatives to dissolution. SANA constitution doesn't allow for a merger. SANA Board proposed that branches mandate: (1) amendment to constitution and (2) negotiations for a merger. National meeting voted in favour of SANA Board proposal.
23 Nov 1995	SANA & DENOSA	Memorandum of understanding: Unity must be achieved; transformation must continue. Both parties will engage with membership and find alternatives. Feedback due: end January 1996.
28 Nov 1995	SANA	Communication with Departments of Health: until negotiations were concluded; SANA continued to exist.
14 Feb 1996	SANA	69 of 85 branches vote in favour of merger and unification process "with any organisation with ... similar objects..." (see 3 Nov 1995 meeting)
5 March 1996 – 9 Sept 1996	SANA & DENOSA	To accommodate a merger: negotiated changes in 15 July 1995 agreement and a new constitution. Deadlock on 3 issues: the legal process of merging; the name of the

Transformation in South African nursing's professional organisations: 1987 to 2001		
Date	Leading organisation(s)	Influencing events
		new organisation and the future positions of staff.
9 Sept 1996	SANA & DENOSA	Agreement reached to merge.
1 Oct 1996	DENOSA	Nine South African nursing organisations, representing ± 100 000 nurses, merged into one unified organisation.
3 Oct 1996	SANA	Central Board farewell dinner.
4 Oct 1996	DENOSA INB	Host celebratory dinner.
5 Oct 1996	DENOSA Joint National Board	First meeting.
5 Dec 1996	DENOSA	Official launch. Keynote speaker: President N. Mandela
June 1997	DENOSA	First National Board elected.
15 Jun 1997	DENOSA	DENOSA joined the ICN.
25-26 Jul 1997	DENOSA	First meeting of National Board.
2-3 Oct 1997	DENOSA	First National Congress.
30 March 2001	DENOSA & COSATU	DENOSA Congress vote with 2/3 majority to affiliate with COSATU.

8.7 A PROFESSIONAL ORGANISATION WITH A TRADE UNION SECTION (1996 TO 2014)

The DENOSA National Board held its first meeting from 25-26 July 1997 under leadership of its first President, Professor Philda Nzimande (DENOSA National Board ... 1997:4). She called on DENOSA members to strive for transparency and democracy in their daily function and acknowledge that it was difficult to establish the trade union structure of the organisation “without compromising ... professional integrity” (Message from the President ... 1997a:6). In her speech at DENOSA’s first National Congress, the President also called on all nurses to participate in the profession’s transformation. The nursing organisation’s permanent name had to be decided on, and a logo that could serve as a unifying symbol was needed (Message from the President ... 1997b:5-6). In 1999, DENOSA members were invited to submit suggestions for a new logo. As on previous occasions when South African nurses’ participation was needed, the response was poor. The DENOSA National Board eventually voted on suggestions made by the organisation’s working committee. They chose a design that contained a protea and a burning lamp with the logo: “United we care and share” (Logo for DENOSA 1999:5).

Referring to the future role of DENOSA, its first President, Prof PN Nzimande, denied that the organisation was simply another trade union: “DENOSA has always been, and still is, the only professional nursing organisation for nurses of South Africa” (Transformation towards ... 1999:4). She reminded nurses of DENOSA’s Institute for Professional Development, which provided courses for professional development. She also mentioned the organisation’s aims, one of which was to “achieve progress for nursing and midwifery in South Africa in all areas of importance to them” (Transformation towards...1999:4). A letter published in the *Nursing Update* later that same year illustrated that not all DENOSA members agreed with the President. The author expressed her concern about the editor’s referring to DENOSA as a professional association: “It was registered from the start as a union” and demanded that the editor retract the statement as it would “harm the organisation’s image” (Concern expressed ... 1999:17).

The organisation joined the ICN and the Commonwealth Nurses Federation (CNF) on 15 June 1997 (DENOSA now member ... 1997:5; Message from the President ... 1997a:6) and soon had working relationships with the Canadian Nursing Association and the Kellogg Foundation (Editorial 1997:3). By the year 2010, the organisation had partnerships with the South African Medical Association, the Southern African Network of Nurses and Midwives (SANNAM), the WHO, the UN, the ILO and the East, Central and Southern Africa College of Nursing (ECSACON). DENOSA was also committed to building partnerships with other political and professional organisations (Brookes 2010:2; Message from ... 1999:5).

8.7.1 New labour legislation affects nurses in the public sector

After 1994, it became mandatory for public sector employees to belong to a union (DENOSA and SAMA ... 1998:11; Geyer, Mogotlane & Young 2015:58). A new bargaining structure, the Public Service Bargaining Council (PSBC) was established. South African nurses working in the public sector resorted under the PSBC, as only teachers and the police service were given specific bargaining councils (Know your ... 1997:16; Know your ... 1998a:38-39; Know your ... 1998b:34-35). SANA’s and DENOSA’s calls for a nurse-specific sector chamber fell on deaf ears (Clow 1998:13; Feedback on...1995:6; SANA reacting ... 1995:9). To participate in collective bargaining in the PSBC, a workers’ organisation needed 50% + 1 members (Zondagh 2001:10-11). To represent public sector nurses and to have access to the bargaining structure where

nurses' socio-economic interests could be represented, DENOSA therefore needed a large membership. The challenge was also that decisions made in the PSBC were made with the welfare of all workers in mind, some of which, such as workweek hours and removing Sundays' monetary compensation, were not in nurses' interest (Mngomezulu 2000:1).

8.7.2 Access to the PSBC and NEDLAC required

In her first speech as the DENOSA President, Professor Nzimande outlined the challenges that the new nursing organisation faced, to be recognised as the voice of the profession. Although DENOSA made representations about the proposed Termination of Pregnancy Bill, the new Nursing Act and Essential Services, "our position [was] not taken seriously", while in the public bargaining chamber nurses believed that they were "discriminated against ... ignored ... suppressed and exploited" (Message from the President 1997b:5). The new nursing organisation also needed money to develop its trade union leg. Some nurses, including the DENOSA Board, believed that the organisation should join a South African federation that had influence on government policy and would enable nurses' participation in the formulation of socio-economic policies. DENOSA would also benefit from union leadership training presented by federations (Gwagwa 1997:7-8; Message from the President ... 1997b:5-6).

Being a new organisation in the world of trade unionism, DENOSA had to increase its membership, obtain support in bargaining forums and gain access to NEDLAC. DENOSA would therefore benefit if it joined a large multi-industry federation such as COSATU, which had access to NEDLAC and was in alliance with the ruling political party. The risk of joining a trade union federation was that the nursing organisation might lose some of its more conservative members. DENOSA's first National Congress debated the matter. It was pointed out by some that a politically influenced federation might not be in the interest of DENOSA members. The Congress made no formal decision about joining a federation, but indicated that the DENOSA National Board must continue discussion and consultation on the matter (Gwagwa 1997:7-8).

At its second National Congress (28-30 March 2001), more than 200 of the 300 DENOSA delegates voted in favour of the organisation's joining COSATU. Some of the organisation's prominent leaders resigned in protest and the organisation entered a

period of turmoil (Congress kicks off ... 2001:17; Mzolo 2001a:9; Mzolo 2003:15). Critics of DENOSA's decision to affiliate with COSATU feared that the nursing organisation would lose its independence and that professional matters would play second fiddle to collective workers' interests. COSATU's political alliance with the ANC and the SACP also raised eyebrows. Articles published in the *Nursing Update* defended the decision to affiliate with COSATU because the federation was consulted by government when policies were developed, although it was acknowledged that it was a power relationship that might change in future. One author denied that DENOSA's independence would be compromised by its affiliation with COSATU, called criticism a "disinformation campaign" and guaranteed readers of the "preservation of the values of our nursing profession" (Makhanya 2001:34).

DENOSA's application for membership of COSATU was formally accepted at the federation's Central Committee meeting held from 19-21 November 2001 (DENOSA to ... 2001:8). Other organisations such as the South African Democratic Nurses' Union (SADNU), the National Education, Health and Allied Workers' Union (NEHAWU) and the South African Municipal Workers Union (SAMWU), which represented nurses, also affiliated with COSATU (Mzolo 2001b:44; Mzolo 2003:16). On 2-3 October 2002, DENOSA members joined COSATU in a protest march (Mzolo 2002b:2). Never in the past had South African nurses' largest professional organisation engaged in industrial action. DENOSA expected all its members to behave professionally and trained its shop stewards in appropriate dress code and conduct in public. Members were reminded that disciplinary action would be taken against those breaking the code of conduct (Kgang 2001:11-12).

By 2004, South African nurses joined numerous trade unions, of which only DENOSA and SADNU were exclusively for nurses. Some nurses were members of more than one trade union. Approximately 80 000 of the approximately 177 000 nurses on the SANC register were DENOSA members. Concerns were raised that the professional organisation was not strong enough, due to a decline in membership, and that South African nurses would never have one voice if there were so many nursing organisations (Mafalo 2003b:4; Matebeni 2010:24; Mzolo 2004a:25). DENOSA's sixth National Congress (held 22-24 October 2010) noted "the battle for control of nursing" and resolved that "T[t]here is a continuous battle for control of the nursing profession from all fronts, and there are clearly deep-seated, yet unresolved, historical divisions based on class,

race and gender” (DENOSA 6th ... 2010:28). The editor of the *Nursing Update* declared that racial tension changed to ethnic tension in the post-1994 era: “we find tension arise out of ethnic differences, such as Sotho and Pedis, Ngunis and Tswana or Vendas” (Mzolo 2002a:2).

DENOSA’s 2010 Secretariat Report confirms that the organisation struggled to increase its membership numbers (Doing great things 2010:26). Its outgoing president urged the organisation to recruit more members and expressed his concern about the young nurses “whose unprecedented scepticism on this dualism [trade union; professional organisation] is worrisome” as their vision was “to collapse DENOSA” (Mafalo 2010:25). Reflecting on the progress of the nursing profession after 1996, he concluded that nurses’ involvement in politics was a two-edged sword. On the one hand, political appointees could influence policy making, but politics also caused damage: “We gradually are drifting away from our responsibilities as professional people to a lesser position as ordinary labourers” (Mafalo 2012:40-41).

One of the options discussed by the DENOSA provincial congresses to increase membership was permitting health-care workers other than nurses, such as lay health-care workers and physiotherapists, membership of the organisation (Discussion points ... 2004:7; Mzolo 2004b:15). A few years later, when the DENOSA constitution was revised, it was decided not to grant other health-care professionals membership (Matebeni 2010:24). Had the nursing organisation accepted that option, it would have been the first time in South African nursing’s 90-year-long involvement in professional activities (1914 to 2004) that health workers other than nurses and midwives were accepted as members.

8.7.3 DENOSA’s involvement in nursing education

The second President of DENOSA stated that poor training led to poor nursing care and questioned the two-tier system of nursing training which saw students at nursing schools obtaining diplomas and others obtaining nursing degrees at universities. Mr Mafalo believed that the plight of South African nurses would only change if the nursing education system “which was designed as apprentice for cheap labor to support the apartheid system” was changed (Mafalo 2003a:39).

The South African Qualifications Authority (SAQA) Act (58 of 1995) required that training institutions register all the courses they presented by 30 June 1998. Training courses had to be restructured to comply with SAQA and Outcomes Based Education (OBE) requirements. Nursing was classified under the Health Science and Social Work field. Initially only four of the thirty nominees for that field's National Standards Body (NSB) were nurses. DENOSA's nominee was rejected because SANC represented the nursing profession on the NSB. However, several other labour unions such as NEHAWU, the Professional Health Organisation of South Africa and the National Union of Mineworkers (NUM) had representation (Geyer 1998:26-28). A few years later, when the Health and Welfare Sector Education and Training Authority (HWSETA) was appointed under the Skills Development Act (97 of 1998), Ms T Mngomezulu was included as a member representing organised labour. She was also a member of DENOSA (HWSETA appointed 2000:26; Skills Development Facilitator 2000:24).

8.7.4 DENOSA's influence on social health issues

South Africa's post-1994 democracy opened the international doors of employment for its registered nurses. The migration (and loss) of skills out of the country caused concern, because it came at a time when the country was engaged in restructuring its health-care system to focus on primary health care and was facing an HIV/AIDS epidemic (Congress kicks off ... 2001:14; Lot of work ... 2010:26). DENOSA called on the government to act decisively in managing the disease and the impact it had on nurses' burden of work and exposure to infection (Aids statistics ... 2000:1; Congress kicks off ... 2001:15). It also organised an international meeting titled "Nurses breaking the silence on HIV/AIDS" (Sept 2000), launched HIV/AIDS fact sheets and discussed the health problem at its 2001 National Congress (DENOSA breaks silence ... 2000:1). At its third national congress, the nursing organisation congratulated the government for its "dramatic turnaround on its HIV/AIDS policy", for example by implementing the mother-to-child prevention programme (Gwagwa 2002:18-19).

South Africa's Termination of Pregnancy Act (92 of 1996) drew severe criticism from the DENOSA Joint National Board because it was passed by parliament without the conscientious objection clause. The professional organisation reiterated that nurses should have the right to choose whether or not they wished to participate in the termination of pregnancy (TOP). DENOSA requested an urgent meeting with the Minister

of Health and published its position paper on the subject. The position paper clarified the rights of the pregnant woman, the right of the nurse and nurses' responsibilities (Changes to ... 1997:4; DENOSA position paper ... 1997:5). A 1997-1998 survey indicated that 64% of South African nurses who participated in the poll objected to TOP (Letters 2000:11).

8.7.5 DENOSA's submission to the Truth and Reconciliation Commission

South African nurses broke the silence about their experiences during the apartheid years by means of a collective written and oral submission to the Truth and Reconciliation Commission (TRC). DENOSA held a workshop in November 1996 to discuss the role of the health-care profession in human rights violations during the apartheid years. DENOSA members were invited to send their submissions to the organisation, which would then send them to the TRC (DENOSA 1997:5-6; Submission to ... 1997:4). In planning the submission, DENOSA recognised that in the period March 1960 to May 1996 (the period reviewed by the TRC) "nursing has functioned within a specific political environment which placed limits on professional and ethical practice" (Clow 1997:5). In the stated period, the nursing profession did not challenge the socio-political system but implemented policies that were forced on them which conflicted with their ethical values. The health sector hearings were scheduled to occur on 17-18 June 1997 in Cape Town. Oral presentations were given by DENOSA, the South African Interim Nursing Council and a few individuals (Clow 1997:6). DENOSA's submission addressed matters pertaining to professional ethics and conduct, the organisation of nursing, nursing education and issues in the nursing services. The South African nursing profession committed to promoting the rights of all persons and to promoting an unbiased health care system (Clow 1998:12-13; DENOSA 1997:54-55).

8.7.6 The relationship between DENOSA and SANC

A change in the relationship between South African nursing's largest professional organisation and its regulatory body, SANC, became noticeable. In earlier years, the two organisations had worked together in establishing and promoting the nursing profession. In the 1990s, that solid relationship was still evident in DENOSA's strong objection to a proposal by the Department of Health to establish only one national council for all health-care professionals. The professional nursing organisation believed (a view supported by the ICN) that South African nurses should retain their identity and autonomy gained in

1944 when SANC was established (DENOSA rejects ... 1997:9). It continued to defend the nursing profession's autonomy and objected to a proposed new Nursing Bill which would give the Minister of Health full control over nursing's governing body. The bill made provision for the minister to select and appoint SANC members, which meant that the nursing profession provided funding (by means of yearly registration fees) for SANC to function, but had very little input into who served on its behalf (Geyer 2005:33).

However, in the late 20th century and early 21st century, the role that each organisation played gradually became more pronounced and at times even contentious. DENOSA in its trade union role firmly supported its members in matters of service and practice, while SANC continued to regulate nursing's standards of practice. In 1997, DENOSA and the nursing profession requested amendments to the Nursing Act (50 of 1978) to ensure that there would be adequate representation of all stakeholders on the South African Interim Nursing Council. The Nursing Bill passed by the National Assembly on 13 March 1997 ensured that all categories of nurses were represented on SANC. DENOSA however was "not altogether happy by all proposed amendments to the Bill" (Amendment of Nursing Act 1997:6). In fact, "much controversy" and "deep divisions" resulted (New Year message ... 1998:5). In 2004, SANC was criticised for not consulting the profession more on changes in the Nursing Act and for considering identity cards instead of distinguishing devices for South African nurses (Zondagh 2004:24-25).

SANC was also criticised by DENOSA for humiliating nurses in its disciplinary hearings, which at times were perceived as a "kangaroo court" (DENOSA questions ... 2004:13). DENOSA reminded SANC that "the nurses of South Africa are paying the expenses of this council" (DENOSA questions ... 2004:13). When submissions for a new Nursing Bill were made, DENOSA continued its objection about the style of SANC's professional conduct hearings and the proposed Nursing Bill's "underlying punitive approach" (Geyer 2005:33-34). Some nurses believed that SANC did not consider the working conditions which nurses endured and called on the council not only to protect the public but also to ensure that health-care institutions were well staffed. It was believed that the council should do more for nurses by putting pressure on the government to train more nurses (Mgidlana 2006:46).

8.8 DEDUCED FROM THE DATA: VULNERABLE INSIGHTS

From the 1970s to 2014, the South African nursing profession and its professional organisations experienced two periods of transformation. Firstly, professional nursing organisations were divided by political apartheid policies which forbade multiracial workers' organisations and forced the establishment of numerous nursing associations and governing bodies in the so-called homelands. The autocratic socio-political system, SANA's statutory position and women's subservient position in South African society meant that few nurse leaders openly challenged the leaders of the day. Rather, they devised methods and structures (such as LONASA) to negate the effect that the policies had on the professional development of specific groups of nurses.

South African nursing organisations' second period of transformation was enabled by the socio-political changes of the late 1980s. The fragmentation that characterised the profession (due to the first transformational period) and SANA's statutory status made the second transformation process exceptionally challenging. In fact, philosophical and socio-political differences would further fragment the nursing profession. While SANA in the last years of its existence declared itself a professional association with a trade union section, DENOSA transformed into a predominantly trade union with a professional section. In reaction, independent specialised professional nursing societies started to develop, leaving South Africa's largest professional nursing organisation unable to increase its member numbers.

Figure 8.4 provides a historical timeline that illustrates the significant events that occurred in South Africa, the world at large, and its influence on the development of South Africa's professional nursing organisations.

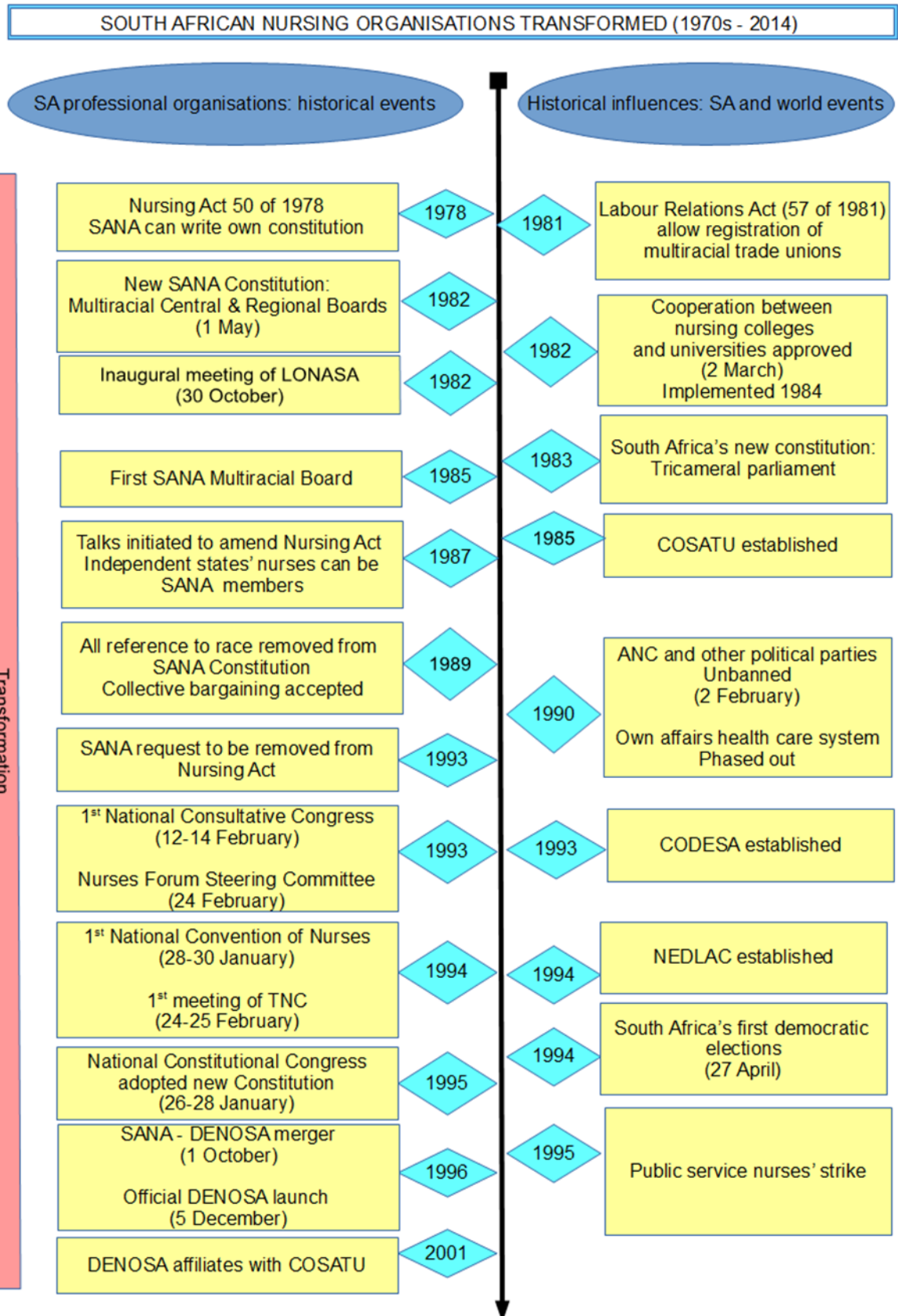


Figure 8.4 The transformation of South African nursing organisations in historical context

8.9 SUMMARY

South African nursing organisations experienced two phases of transformation and one attempt at unification. The nursing profession lost its unified voice and fractured into numerous nursing organisations due to the socio-political influences of the apartheid years. Later, when apartheid as a political force started its decline, South African nursing organisations reconnected and negotiated to establish one professional organisation that could serve all nurses. The outcome of these negotiations was that one organisation (DENOSA) was established in 1996. DENOSA was a professional association with a trade unionist stance. Not all professional nurses accepted this outcome and therefore philosophical and socio-political differences continued to divide the profession.

CHAPTER 9

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

9.1 INTRODUCTION

The researcher studied the influential South African nursing organisations of the past one hundred years (1914 to 2014). Chapter 8 concluded the data collection and analysis phases of the research. Guided by the vulnerable insights that emerged from the narrative (chapters 4-8), in this final chapter the researcher concludes with invulnerable insights.

The chapter identifies the social factors that influenced the development of South African nursing organisations and illustrates how changes in nursing organisations over time influenced the professional development of South African nursing itself. By performing their professional, social, political and educational functions, these professional organisations contributed to the development of the nursing profession in South Africa.

The chapter commences by clarifying the importance of professional organisations and summarising types of professional organisations. The philosophical underpinnings and the research methodology that guided the study are briefly explained. The remainder of the chapter contains the concluding statements about the research objectives. The researcher makes recommendations that can assist the nursing profession in its policy making, educational and research activities. The final section of chapter highlights the contributions the study makes to the scientific body of knowledge.

9.2 THE IMPORTANCE OF PROFESSIONAL ORGANISATIONS

Professional organisations develop vocational groups' identity, which in turn assists group members to increase their value and status as workers (Geyer 2013:199). An organised profession increases its authority and political influence so that the group can achieve its stated objectives (Searle 1982b:4-6; Searle 1991:6). The first to establish a professional organisation was the BMA in 1832. The RBNA followed suit in 1887 under the leadership of Mrs. Ethel Gordon Bedford Fenwick (Marks 1994:15; Searle 1991:6, 15-16). A branch of the RBNA was established in Kimberley, South Africa, where Sister Henrietta Stockdale

worked as a district nurse and midwife. In 1891, Henrietta Stockdale, with the support of members of the BMA, obtained voluntary state registration for nurses in the Colony of the Cape of Good Hope – the first group of nurses in the world to formalise their authority and influence (Searle 1991:6, 11-17, 19). On 1 October 1914, the first influential South African professional nursing organisation, SATNA, was established (Searle 1982a:17).

Professional organisations inform society and policy makers on issues specifically related to their speciality. These organisations consider the welfare of society by ensuring quality of service. Members of a professional organisation themselves benefit, as evident in their personal and professional development (McQuide et al 2007; National Business Education Association 2010). Three types of professional organisations are evident in the literature: professional associations, trade unions and an organisation that has both trade union and professional association characteristics. Traditionally trade unions and professional associations are viewed as opposing entities because they differ in the professional culture they create, the ethical values they support and their reason for action (Hovekamp 1997:232-244; Searle & Pera 1993:82-85, 341; Van Huyssteen 1984:5-10). This thesis, informed by critical realism, has explored South African nursing organisations' transformational changes, identified the causative mechanisms which historically imposed such changes, and reflected on how these influenced the development of the profession.

9.3 CRITICAL REALISM GUIDED THE HISTORICAL INQUIRY

Critical realism enabled the researcher to explain and critique the social world in which South African nursing organisations functioned and over time exerted their professional influence. By concentrating on the real domain of critical realism, the focus of the research moved away from *what* historical events occurred, to *what caused* events to occur and *how* they influenced the professional development of nursing in South Africa. From the initial vulnerable insights, the researcher achieved invulnerable insights that illustrate how changes in nursing organisations over time have influenced the professional development of South African nursing. The professional, social, political and educational functions of these nursing organisations became evident.

Critical realists state that our interpretation of the social world is based on our perceptions of that world. Human interpretations of social events therefore hold elements of truth, but

it is never the ultimate truth. In fact, multiple truths are possible. The researcher accepts that conclusions derived from the historical inquiry into South Africa's professional nursing organisations are based on the philosophical lens used and the historical documents read. The research conclusions therefore have the potential to stimulate debate among members of the nursing profession who might have different philosophical views or who gain access to previously unavailable historical documents.

The **objectives of the research** were to explain the factors that influenced the development of South African nursing organisations evident from 1914 to 2014, and to explain how these organisations in turn influenced the professional development of South African nursing (note sub-section 9.4.1). South African nursing organisations' professional, social, political, and educational functions are described (note sub-section 9.4.2). Finally, the research illustrates that South African nursing organisations created an independent, recognisable professional presence in South African society and assisted in the professional socialisation of nurses in South Africa (note sub-section 9.4.3).

The **literature review** was guided by the research purpose and the use of specific inclusion and exclusion criteria. The data sources were any primary or secondary literature sources (e.g. books, photographs, minutes of meetings, speeches and journalistic media) that explained the history of South African professional nursing organisations. Unobtrusive and naturalistic **data collection** methods were chosen, using the *researcher* as the data collection instrument (Lincoln & Guba 1985:224; Nieuwenhuis 2010b:78-79; Streubert & Rinaldi Carpenter 2011:89). Qualitative researchers and critical realists (Benton 2011:2-3; Lincoln & Guba 1985:187, 195-198) accept that the researcher is part of the research; not a detached entity. The human research instrument is valuable due to his or her ability to use tacit knowledge (a way of understanding that which is difficult to explain, but essential to human insight into life's events). The use of *a priori* **codes** gave the human research instrument direction about the historical data that had to be collected, so that data saturation (crystallisation) could be reached.

Data analysis was not a distinctly recognisable phase of the inquiry. Rather, it was a much-repeated cycle of reflecting on the meaning of data collected and, guided by the questions arising from such analytic reflections, analysing more (newly collected) data. In this way vulnerable and invulnerable insights were obtained (Fletcher 2017:184). The

cyclical nature of the data analysis was supported by Lonergan's (1980:222-223) three cognition levels, which explain that repeated and reflective reading of the data allowed the researcher to gain insight and knowledge of reality. To ensure that the researcher complied with the **ethical** requirements of historical research, bracketing by means of a reflective journal was done. A self-evaluation ethical compliance checklist was also signed by the researcher at the end of the study (note Annexure C).

9.4 INVULNERABLE INSIGHTS: CONCLUSIONS OBTAINED FROM THE DATA

The thick descriptions and vulnerable insights recorded in chapters 4 to 8 of the thesis contain the real world's veiled structures, agents and causative mechanisms. The narrative illustrates relationships and interactive powers that influenced actual world nursing organisations and consequently the development of the nursing profession in South Africa. In the section below, the invulnerable insights answer the research objectives and conclusions are reached.

9.4.1 Factors that influenced South African nursing organisations and consequently the development of the profession

This section explains the factors that historically influenced the development of South African nursing organisations (objective 1). It also explains how changes in these organisations over time influenced the professional development of the profession (objective 2).

9.4.1.1 Socio-political influences

In the late 19th century, British notions of social class, wealth and education created a class-conscious, segregationist society in colonial Southern Africa. By the early 20th century, this socio-political stance became evident in South African nursing's organisational structures and policies. SATNA was established in 1914 by British nurses for trained, registered nurses only. Education, state registration and the resultant professional nurse's image created an elitist organisation in which locally trained nurses had little opportunity to participate. This elitist stance led to the establishment of BTNA, a nursing association that accepted registered and lesser trained nurses as members. By the 1930s, the SATNA branches also became racially segregated.

The outcomes of the South African War (1899–1902), WWI (1914–1919) and WWII (1939–1945) contributed to South Africa becoming a country where its people were politically, culturally and racially divided. Shortly after WWI, African workers were not allowed to join European, Indian or Coloured trade unions in South Africa (Brits 1993:166; Mager & Mulaudzi 2011:376-377). The 1948 general election would further the social divide and create the apartheid system and the so-called homelands or independent states. Apartheid's laws of segregation necessitated the establishment of nursing organisations in each of the homelands; effectively dividing Southern Africa's nursing profession.

Racial segregation in South African nursing was formalised by the Nursing Act (69 of 1957) (South Africa 1957). As a member of the ICN, SANA was criticised for its apparent support of apartheid legislation. SANA tried to explain its position as a non-political nursing organisation on two occasions: in 1957 and again in 1973. SANA's philosophical opposition to strike action, financial constraints and a desire to protect the elitist professional image of the registered nurse motivated the association to leave the ICN in 1973. The decision isolated South African nurses from the largest international gathering of professional nurses that decided on matters of professional development. Perhaps the subtlest form of political criticism and resistance was in South Africa itself, where many SANA members did not pay their compulsory membership fees and did not participate in professional activities.

In the 1980s, the gradual abandonment of the apartheid system altered South Africa's political landscape. The Labour Relations Amendment Act (57 of 1981) made provision for multiracial trade unions (Liebenberg 1993:470) but by that time South African trade unions were already politicised (and actively opposing the apartheid system). The Nursing Act (50 of 1978) (South Africa 1978) was the first in which the functions of SANA were not prescribed. SANA could retain compulsory membership, write its own constitution (approved by the Minister of Health) and regulate its own affairs. SANA's 1982 constitution made provision for the decentralisation of the organisation and the establishment of multiracial regional and central boards. The first multiracial SANA Central Board was elected in 1985. Seven years later, the 1989 SANA Constitutional Congress removed all reference to race from the association's constitution.

9.4.1.2 *Socio-economic influences*

Late 19th-century industrialisation facilitated the entry of women, traditionally not economically active, into the workplace. Valuable female workers such as nurses emerged and had to be paid for their skills. The result was a liberal socio-economic society in which men suddenly had to compete with women in the labour market. In South Africa, however, nursing remained a low-paying occupation with no independent professional status, and was controlled by the four provincial Medical Councils.

It was important to establish the female professional nurse image, as this would elevate nursing from being something all women could do to something that only trained women could do. In South Africa, Sister Henrietta Stockdale and Dr MacKenzie extended their nurse-training programme to ensure international (British Nursing Association) recognition. Well-trained nurses with exclusive professional skills created economic bargaining power. Although beneficial for SATNA members, such professional exclusivity in later years contributed to the nursing shortage experienced in South Africa; few nurses could comply with the training standards required.

By the early 20th century, South Africa experienced labour strikes (1913–1914) and witnessed the emergence of trade unionism. Black workers realised that their economic advancement was dependent on an enabling political environment and so trade unions became involved in politics. The Industrial Coalition Act (28 of 1956) prohibited the registration of new trade unions with racially mixed membership and forced existing trade unions to establish racially separated branches (Liebenberg 1980:496).

Dynamics of power became evident in South African nursing during the 1940 to 1942 trade union crisis, when the mostly middle-class Afrikaner and junior nurses voiced their dissatisfaction about the professional dominance of elitist British nurses. The 1942 trade union crisis was a rivalry between a professional nursing association and trade unionists for the position of power in South African nursing. The SATNA successfully campaigned against trade unionism in nursing and facilitated the passing of South Africa's first Nursing Act (45 of 1944) (South Africa 1944). This act made provision for the establishment of SANA and SANC. SANA became the only recognised South African nursing association; a position of dominance from which it functioned for 52 years (1944 to 1996). Membership of SANA was compulsory and effectively created a closed nursing profession. With the

promulgation of the Nursing Act (50 of 1978) and SANC Regulation (no 387), South African nurses lost the right to strike (Searle 1987b:289, 292; Searle 1987c:305-306). Registration with SANC became compulsory, which meant that only registered, trained nurses could practise the art of nursing. Yet, nursing remained a poorly paid, economically undervalued profession.

In the early 1980s, SANA revised its constitution in response to several internal and external influencing factors. External factors included South African society's opposition to the apartheid system and changes in legislation, such as labour laws. Internal factors that challenged the status quo included SANA members not paying their membership fees, low voting rates during board elections and inactivity in branch meetings. Most important was the SANA Board's growing awareness of its members' insistence that the association develop into a trade union because this was viewed as the best vehicle for negotiating conditions of service. Although they could join trade unions, South African nurses were barred from having trade union representation in the workplace. Only SANA could negotiate on behalf of nurses about conditions of service.

South Africa's political transformation during the 1990s necessitated strategic changes in the country's largest professional nursing organisation. In the public sector a new bargaining structure, the Public Servants' Coordinating Bargaining Council (PSCBC), which negotiated issues common to all public servants as well as those who did not have a specific bargaining council, was established. South African nurses working in the public sector resorted under the PSCBC, as only teachers and the police service were given specific bargaining councils. SANA's and DENOSA's calls for a nurse-specific sector chamber fell on deaf ears. In November 2001, DENOSA, with which SANA had merged in 1996, therefore joined COSATU, a large multi-industry federation which had access to NEDLAC and was in alliance with the ruling political party. By 2002, DENOSA members joined COSATU on a protest march. Over time, trade unions in the PSBC focused their negotiations on issues of general concern; some of which were not in nurses' interest.

By 2004, South African nurses joined numerous trade unions, of which only DENOSA and the SADNU were exclusively for nurses. Concerns were raised that South African nurses would never have one voice if there were so many nursing organisations.

9.4.1.3 Socio-cultural influences: gender

The traditional 19th-century British social system positioned educated men (doctors) in the decision-making roles, while working-class women (nurses) were expected to serve. Internationally, female nurse leaders realised that they had to address political, educational and gender inequality if they wished to succeed in raising nursing to a professional status. However, early 20th-century female nurse leaders needed male (medical and political) support to legitimise their claims of professionalism, while at the same time realising that those very same supporters might hamper the struggle for equality. Such gender-based dynamics limited the development of professional nursing organisations and consequently the independent professional practice of nurses. In 20th-century South Africa, social and political power remained in the hands of men. Although female-led nursing organisations advocated for the development of nursing as a profession, such activities were conducted within the constraints of social decorum.

Table 9.1 gives a summary of the factors that influenced the development of South African nursing organisations and the profession itself. Guided by critical realism, the first column contains the causative mechanisms that were identified in the study while the second column contains statements about their influence on nursing organisations. The last column in the table illustrates the consequent effect on the South African nursing profession.

Table 9.1 Summary of the factors that influenced South African nursing organisations and consequently the development of the profession

Causative mechanism	Influence on South African nursing organisations	Effect on the South African nursing profession
Socio-political	British nurses' dominance in elitist SATNA	Lesser trained nurses excluded; established own association
	British social class system: wealth, education and race Post-WWII: apartheid policy: Nursing Act (69 of 1957)	Racial segregation in nursing Black nurses politicised
	Nursing Act (50 of 1978): functions of SANA not prescribed	1982: multiracial SANA regional and central boards
	SANA: 1982 constitution Labour Relations Act (57 of 1981) allows multiracial trade unions	1985: first multiracial SANA Central Board 1989: reference to race removed from constitution
Socio-economic	19 th century Industrialisation	Women (nurses) enter the workplace Low-paying occupation
	Create professional image and demand high educational standard	Exclusive skills: bargaining tool Limited candidates: nursing shortage
	1942-1944 trade union crisis	Philosophical and class divide
	Nursing Act (45 of 1944): one compulsory professional nursing association	Nursing a closed, state-controlled profession Nurses may not strike
	1990s: transformation in nursing organisations	Trade unions preferred as bargaining tool
	2001: nursing organisations join a large trade union federation to increase public service bargaining power	No single, united voice that speaks on behalf of nurses in South Africa The profession became entangled in generalised trade union matters
Socio-cultural (gender)	Male dominant society: doctors, medical councils and politicians	Nurses' (females) subservient role Limited independent professional nursing practice
	Development of nursing organisations dependent on male support	Vulnerable to social and political influence (e.g. apartheid laws)

9.4.2 The functions of South African nursing organisations

This section describes how South African nursing organisations historically contributed to the development of the profession by performing their professional, social, political, and educational functions (objective 3).

9.4.2.1 Professional function of South African nursing organisations

In the late 19th century, the small group of trained nurses in South Africa had no formally recognised professional organisation to speak or act on their behalf. Informally, Sister Henrietta Stockdale acted as the nurses' collective, professional voice. Her role, as well as social constructs such as gender, politics, war, geography and unreliable means of communication, initially limited the development of influential nursing organisations in South Africa.

Historically, the religious sisterhoods bestowed on South African nursing its principles of disciplined practice and its philosophy of selfless service. From 1914 to 1996, SATNA and SANA entrenched that ethical foundation into the psyche of South African nursing by means of speeches (e.g. at the ICN in 1957 and 1973) and in nursing literature. In this way, the professional organisations had a considerable influence on the socialisation process of South African nurses.

By restricting membership of the first professional nursing organisation to trained registered nurses only, SATNA created professional exclusivity and status. The professional image of nursing was paramount, as professional status increased credibility and influence on policy makers. It also provided nurses with collective bargaining power. However, SATNA's elitist social and educational stance limited the participation of other cultural groups and non-registered nurses in developmental activities. Later, SANA protected the professional image and philosophy of South African nursing even to the extent of isolating the profession from the largest international nursing organisation (the ICN). For that decision, it was criticised by the liberal sections of South African society.

A legacy bestowed on South African nursing by its first influential organisations is the professional associations evident today. Over time, SANA discussion groups established in the 1950s to discuss nursing-related topics evolved into specialist groups. By the

1980s, SANA invited these specialist groups to apply for recognition by the association as national professional societies (e.g. the National Society of South African Theatre Sisters). After South African nursing's organisational transformation in the 1990s, some of these professional societies became independent nursing organisations.

9.4.2.2 Educational function of South African nursing organisations

Historically, South African nursing organisations appreciated the statutory exclusivity and socio-economic advantages of a trained profession and continuously advocated better standards in nursing education. It was recognised that the economic welfare of nurses depended on the exclusivity of their skills and services. The paragraphs that follow serve to illustrate how nursing organisations influenced the educational standard of South African nursing.

Before the establishment in 1944 of South African nursing's governing body in nursing education matters (SANC), Sr Henrietta Stockdale and SATNA used education and the creation of an educated nursing elite to establish nursing as a profession. This led to South African nurses being awarded statutory status in 1891. In later years, SATNA campaigned for the right to display trained nurses' professional status by means of an exclusive nurses' uniform and insignia.

Since the promulgation of the first Nursing Act (45 of 1944) (South Africa 1944), SANA cooperated with SANC to develop a system of nursing training which set the standards of nursing care. South African nurses were professionally empowered due to SANA's drive for scientific, tertiary and post-basic nursing training. The association was instrumental in the establishment of the first Chair of Nursing at the University of Pretoria. Through the 1980s and 1990s, SANA continued its efforts to raise nursing education to tertiary education level. SANA further established an internal division that promoted nursing research and trained nurses in research work. The nurses of South Africa gained access to nursing literature when SANA established a scientific nursing magazine, the *Curationis*, encouraged the publishing of nursing books and established a library at its head office in Pretoria.

After the establishment of DENOSA in 1996, the organisation questioned the nursing education system which awarded diplomas to some registered nurses and degrees to

other registered nurses. Changes in South Africa's higher education legislation necessitated the moving of nursing education to the higher education domain and the restructuring of nursing courses, for instance to comply with the SAQA Act (58 of 1995). By 2014, this process had not yet been finalised.

9.4.2.3 Political function of South African nursing organisations

South African nursing's organisations endeavoured to represent the profession and society in work- and health-related matters. Disadvantaged by 19th-century societal thinking about gender (the female role) and dependent on male supporters in the world of medicine and politics, it took SATNA 14 years (1914 to 1928) to secure two nurse representatives onto the SAMDC. Their presence on this decision-making medical council gave nurses their first opportunity to be active (but constrained) participants in their own professional development. SATNA used its political voice to campaign for nurses' conditions of service by calling on those in power to legitimise trained nurses' rights as workers and eliminate the practice of untrained persons. By eliminating untrained nurses, trained registered nurses had more job opportunities. Furthermore, the welfare of the South African society was then also protected because those in need received quality health care from a trained person who could be held accountable.

But the drive for professional status caused division in the South African nursing profession. During the first half of the 20th century, nurses worked in unsatisfactory conditions and were poorly paid. The outbreak of WWII (1939–1945) created a shortage of trained nurses in South Africa and left junior nurses to bear the brunt of nursing care. Locally trained nurses felt mistreated in the workplace. The situation, together with the professional dominance of British nurses in SATNA, gave rise to the 1942 trade union crisis. SATNA used its political skills to effectively campaign against the threat of trade unionism. The Nursing Act (45 of 1944) (South Africa 1944) introduced a closed-shop principle: only SANA members were recognised as workers. The Nursing Act (45 of 1944) (South Africa 1944) also required all nurses practising in South Africa to register with the newly established SANC, thus eliminating the practice of unregistered (untrained) nurses. This resulted in South African nursing obtaining professional exclusivity and a unified political voice.

During the apartheid years (1948 to 1996), SANA used its political voice to make representation to government structures and provincial administrations about the salaries, working conditions and leave privileges of South African nurses. The association also created economic stability for nurses by establishing pension and provident funds, an indemnity scheme and an insurance scheme (the superannuation fund).

In the 1980s, the socio-political changes in South Africa necessitated changes in the country's only recognised nursing association. SANA implemented the concept of collective bargaining, which was traditionally considered a trade union mechanism. In 1996, SANA, realising that its political voice was diminishing, merged with the newly established DENOSA. Abandoning the one professional nursing organisation and closed-shop principle, nurses joined other non-nursing organisations and trade unions. To gain a foothold in public bargaining structures, new, politically weak organisations that represented nurses had to align themselves with powerful non-nursing trade union federations. In the year 2014, South African nursing had professional organisations that were politically engaged, affiliated with general workers' federations and predominantly engaged in trade union activities. To gain economic bargaining power, South African nurses gave up their professional bargaining power.

9.4.3 South African nursing's recognisable professional presence in society

South African nurses created a recognisable professional presence (objective 4) when they became the first nursing group in the world to achieve statutory status in 1891. By instilling the ethical principles of duty, discipline and service, the religious sisterhoods and later South Africa's nursing associations influenced the professional development of nursing. The first Nursing Act (45 of 1944) (South Africa 1944) confirmed such distinctive professional philosophy, created a seemingly unified nurses' professional and political voice and socialised South African nurses against any action (e.g. strike) that might harm patients or society.

The South African nursing profession was, however, never truly unified because lesser-trained nurses were excluded or limited in the extent to which they could participate in the associations' professional activities. Black, Indian and Coloured nurses' rights to professional expression were limited due to the socio-political status awarded them during the apartheid years. Educationally and economically they were disadvantaged due to

SATNA and SANA's drive to improve the status of nursing and create the professional image of nursing by means of an educated elite. This made nurses politically active.

Political activism was evident during the 1993 to 1996 nursing transformation period, when most South African nurses supported the establishment of a professional association with a trade union section. Nurses also joined other non-nursing trade unions. Soon after its establishment on 5 December 1996, the largest professional nursing organisation (DENOSA) actively involved itself in trade union activities to gain economic bargaining power. By agreeing to their members participating in industrial action, South African nursing organisations diminished the profession's unique ethical presence in South African society.

9.5 LIMITATIONS OF THE STUDY

Historical researchers need travel time, archive time, reading time, time to reflect and finally time to record the narrative. The time limitations set by a formal research project (such as a doctoral thesis) do not always tie in with the time-consuming ongoing nature of historical research. The researcher was limited to accessing archives in South Africa known to have nursing-related documents. No international archives were visited. Although online archives made more historical documents available, this form of research was also limiting, as not all documents available in the archive itself are available online. Some valuable nursing documents might therefore lie undiscovered.

To ensure that the invulnerable insights obtained were credible, primary sources were used as much as possible. If primary sources were not available or not found, more than one secondary source was consulted before drawing conclusions about the significance of a historical event. The researcher was for example unable to find the 1914 SATNA constitution in the DENOSA, University of Free State or University of Witwatersrand archives. Enquiries made by telephone and by e-mail to retired SANA nurse leaders also did not bring light on the whereabouts of South African nursing's first professional association's constitution. The researcher therefore had to find information from by-laws and articles published at the time.

The National Archives of South Africa Act (43 of 1996) (South Africa 1996) declares that a document is archival material when it is twenty years old. That limited the researcher's

access to primary sources, because DENOSA's minutes of meeting and memorandums written after 1998 are not yet available in the organisation's archives. The researcher had to submit special requests for specific documents. Due to the limited time accorded to complete a thesis, the researcher opted to make use of the *Nursing Update*, DENOSA's formal communication medium with its members. To ensure that insights gleaned from *Nursing Update* issues were credible and valid, the researcher made use of referencing and direct quotes.

Although the following topics were mentioned, comprehensive investigations into these issues of historical interest were beyond the scope of the research:

- The effect of the SANA and SANC relationship on the development of the nursing profession in South Africa.
- The League of Nursing Associations of South Africa (LONASA's) contribution in fostering unity amongst Southern African nursing organisations.

9.6 RECOMMENDATIONS

Based on the research conclusions the following recommendations are made:

9.6.1 Recommendations for professional development

From 1914 to 1996, South African nursing associations primarily focused on creating a professional nursing image and achieving statutory status for the profession. The focus shifted so that in the period 1996 to 2014, the determination to attain socio-economic wellbeing for nurses became the primary objective of numerous trade unions. It is recommended that South Africa's professional nursing organisations:

- conduct crucial conversations with each other to search for the binding factor that will make it possible for the nursing profession of South Africa to reclaim its united, recognisable professional voice
- use their political voices to collectively communicate South African nursing's philosophical principles and values to members of the profession and the society at large

- examine how each organisation contributes in positioning South African nursing to comply with the international criteria of a profession (given the current trade unionist stance)
- cooperate to establish a centrally managed nursing archive and museum so that South African nurses learn to access and appreciate their unique professional history
- plan a series of special addresses where retired South African nurse leaders who participated in the transitional period of the 1990s share their experiences with current and future nurse leaders
- identify factors that discourage school leavers from choosing professional nursing as a career and work with tertiary education institutions and their approved clinical facilities to correct them

9.6.2 Recommendations for nursing practice

Nursing organisations influence the development of the nursing profession. It is recommended that South African nursing organisations:

- co-operate (unite) to campaign for the establishment of a public bargaining chamber dedicated to the work-related needs of professional nurses
- empower their members to adjust to traditional gender roles that are continuously changing - and to cope with the resultant change in the multidisciplinary health-care team dynamics

It is further recommended that South African nurses:

- participate in professional activities so that they are informed and knowledgeable about the socio-political and socio-economic factors that influence nursing organisations and consequently the nursing profession
- actively participate in the decision-making processes of professional nursing organisations to ensure that the silent majority is not governed by the active minority
- recognise that while professional nursing organisations represent them on socio-economic matters, the organisations also have the responsibility to maintain a caring, trust relationship with society

- reflect on the nursing philosophy professed by current nursing organisations and how that philosophy will influence the ethics of nursing in the future
- demonstrate awareness that their choice of professional organisation influences the nature of their interaction with patients, nursing team members, employers and the public at large

9.6.3 Recommendations for nursing policy

Historically, South African nursing organisations were vulnerable to socio-political and socio-cultural (gender) influences. It is recommended that nursing organisations in the country:

- use Bergman's dynamic consumer-content model (note Chapter 1, sub-section 1.2.2.2.1) to determine which of six key characteristics should be prioritised to ensure that the nursing association is able to support nurses and society
- develop a collective political strategy to determine the role that each organisation can play in advancing the profession and developing its members
- develop a position paper to clarify to what extent party political interests will be allowed to impact on its decisions about nursing matters
- determine how trade unionism influenced the professional socialisation of nurses in South Africa and direct the profession about accepted ethical behaviour while engaged in industrial action
- develop a collective strategy that explains how the nursing profession plans to establish a human rights culture in the health care sector
- establish a clear policy against gender discrimination in the nursing profession and in the broader South African society

9.6.4 Recommendations for nursing education

Historically, nursing education was used by professional nursing organisations to create socio-economic bargaining power and to provide South African society with quality nursing care. It is recommended that South African nursing organisations:

- support and assist the transformation of South African nursing's training institutions into the tertiary education domain

- assist nursing colleges to finalise the development of a new nursing curriculum that complies with SAQA and SANC requirements and produces clinically competent nurses who can address society's current health needs
- assist South African nursing education institutions to develop decolonised nursing history curricula
- encourage their members to commit to the principle of continuous professional development by offering training programmes, seminars and conferences

9.6.5 Recommendations for further research

South African nurses must demonstrate historical awareness so that they can make informed decisions about the profession's future identity. The following areas should be researched:

- the socio-political and socio-economic factors that hampered the professional development of the so-called homeland nursing associations' during apartheid
- LONASA's contribution in fostering unity among Southern African nursing organisations during a challenging political period
- the history and influence of politically active nursing organisations such as the Rand Nurses' Professional Club and the South African Federation of Nurses and Midwives
- the professional relationship between the ICN and South African nursing organisations, to reveal how international support and opposition influenced South African nursing's professional development
- the relationship between SANC and South African professional nursing organisations, to discover how it influences the professional development of South African nursing
- the historical development of SANA discussion groups into professional societies and their current influence on the professional development of South African nursing
- the crucial 1993 Durban conference that led to the establishment of DENOSA in 1996 and role that the late Albertina Sisulu played in facilitating negotiations at that conference

9.7 CONTRIBUTIONS

The study contributes to South African nursing's body of knowledge in that:

- guided by critical realism philosophy and historical inquiry methodology, it identifies the factors that over time (100 years) influenced the development of South African nursing organisations
- it illustrates how over time changes in these professional organisations influenced the nursing profession itself
- it demonstrates the interconnectedness of historical events, confirms that there are multiple known and hidden influencing factors that create historical events and cautions against simplistic explanations of such events
- it reveals how professional nursing organisations effectively used education to create a professional nursing image and professional status

Derived from archival sources the rich, thick descriptions in the narrative inform South African nurses about significant historical events that influenced their profession. In the study the following historical events are comprehensively described in South African nursing literature for the first time:

- the 1942-1944 trade union crisis that led to the establishment of SANA and SANC
- the role of SANA and SANC in the 1955 Select Committee proceedings. The Committee's recommendations influenced the formulation of the racially biased Nursing Act (69 of 1957)
- SANA as a member of the ICN: the influence of Nursing Act (69 of 1957) on professional relations in the 1950s and SANA's membership withdrawal in 1973
- The establishment of LONASA in the 1980s as a communication medium between (by apartheid law) racially segregated nursing associations in Southern Africa
- The process of organisational transformation in the 1990s that led to SANA and the so-called homeland nursing organisations merging into one organisation namely DENOSA
- DENOSA's first 18 years of professional activities, and its influence on the profession

9.8 CONCLUSION

In the past one hundred years, the drive of nursing organisations for professionalism through education ensured statutory recognition for South African nurses. The first professional organisations created a nursing culture that encouraged philosophical and ethical principles of practice. Over time, a social class system, religion, political ideology and economic needs reshaped South Africa's nursing organisations and consequently the profession. Determined to create the female professional image, status and educational exclusivity, the nurse leaders of the 20th century opted to establish a professional nursing association. The result was a recognised, respected and trained nursing corps. By the end of the 20th century, however, South African nurse leaders accepted that nurses needed their socio-economic welfare to be prioritised and therefore a professional organisation with a trade unionist stance was established. The result was a trained, politicised nursing corps struggling to find its collective professional voice. Reflecting on the post-1996 development of the South African nursing profession, the second President of DENOSA concludes that nurses' involvement in politics was a two-edged sword. On the one hand political appointees could influence policy making, but politics also caused damage: "We gradually are drifting away from our responsibilities as professional people to a lesser position as ordinary labourers" (Mafalo 2012:40-41). Socio-economic and political status became more important than professional development and the professional image.

Quo Vadis?

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ANNEXURES

ANNEXURE A

Ethical Clearance Certificate: Health Studies Higher Degrees Committee, Unisa



UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HS HDC/485/2015

Date: 9 December 2015 Student No: 3009-515-8

Project Title: A century of nursing organisations in South Africa: 1914-2014.

Researcher: Johanna Maria Esterhuizen

Degree: D Litt et Phil Code: DPCHS04

Supervisor: Prof GM van Rensburg

Qualification: D Litt et Phil

Joint Supervisor: Prof A Oosthuizen

DECISION OF COMMITTEE

Approved



Conditionally Approved



Prof L Roets

CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof HM Moleki

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES


ANNEXURE B

Data analysis: Reading for historical context

Data analysis: Reading for historical context	
Date/year document was created/written	
Author(s)	
Document title	
Authenticity (external/internal criticism)	Yes/No/Comment
Is the document genuine? Can the document be trusted? Primary or secondary source? Is language and terminology understood within historical context? Historical fact, probability or possibility?	
Section 1: General questions asked of all historical documents	
Who are the significant participants in the historical event? What was their response(s) to the event? Are there factors that conditioned this response? What are these participants' values and believes? At the time of the event: how did the economic, social and political system function? To what extend did ethnicity, class and/or gender matter? At the time, what other historical influencing factors was evident? How did these historical influencers affect groups/persons involved?	
Section 2: Questions specifically asked of this document	
Section 3: New questions arising from reading this document	

ANNEXURE C

Self-evaluation check list: Ethical compliance

Self-evaluation check list: Ethical compliance		
1.	Research was conducted in accordance with the ethical principles of justice and beneficence.	✓
2.	The relevant historical research methodology was applied.	✓
3.	The research purpose, objectives, methods of data collection and the benefit(s) to society are transparent.	✓
4.	Research findings were communicated honestly. Misrepresentation of historical events is regarded as academic dishonesty.	✓
5.	The effect of biases on recorded history was recognised and considered.	✓
6.	The research is meaningful and contributes to nursing's body of knowledge.	✓
7.	Throughout the research process the researcher demonstrated integrity.	✓
8.	Historical participants' recorded words (in documents) are represented with consideration to the participant's privacy, worth and dignity.	✓
9.	Within the confinement of available resources, the historical truth is represented.	✓
10.	History is represented in a responsible manner.	✓
11.	The work of others is valued and acknowledged.	✓
12.	Historical records were valued, not tainted or destroyed.	✓
13.	Reasonable requests from other historians to have access to documents were honoured.	✓
14.	Recognition is given to the fact that historical research creates a golden thread between the present, the past and the future.	✓
	 Signed by: JM Esterhuizen (D Litt et Phil candidate) 8 November 2018 Date	

ANNEXURE D

Certificate of editing

CERTIFICATE OF EDITING – MJ MARCHAND

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Tel/Fax: (012) 460 5727
Cell 082 343 0325
E-mail: marchm@iafrica.com

14, Twenty First Street
MENLO PARK
Pretoria
0081
2 November 2018

To whom it may concern:

I certify that I am a professional, experienced and accredited editor and that I have edited, chapter by chapter, the PhD dissertation by Johanna Maria Esterhuizen, entitled “The influence of nursing organisations on the development of the nursing profession in South Africa: 1914–2014”.

I have edited the dissertation for clarity, correctness and flow of language and expression. This included spelling, tense, vocabulary, number, punctuation, pronoun and verb matches, word usage, correct acronyms, sentence structure and consistency. I also carefully checked the many references with the text.

The dissertation left my hands on 2 November 2018. I am not responsible for later additions to the text.

Marion J Marchand
BA, H Dipl Lib, HED,
Postgraduate Certificate in Editing UP; Accredited Translator (Afrikaans to English) and English Editor, South African Translators' Institute, Member of the Professional Editors' Guild; Member of the English Academy

ANNEXURE E

Confirmation of editing

PO Box 1681
Brooklyn Square
0075 PRETORIA

4 June 2019

TO WHOM IT MAY CONCERN

CONFIRMATION OF EDITING OF DOCTORAL THESIS

This letter serves to testify that I have edited the doctoral thesis of Johanna Maria Esterhuizen, entitled "The Influence of Nursing Organisations on the Development of the Nursing Profession in South Africa: 1914-2014", to conform to the language, stylistic and technical standards of a doctoral thesis.

I undertook this work between 28 May and 4 June 2019.

Please do not hesitate to contact me if you require further information.

Yours sincerely



NICHOLAS SOUTHEY

Email: ndsouthey@mweb.co.za

Tel: 082 896 6478

ANNEXURE F

Turnitin originality report

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